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EARLY AND PERIODIC SCREENING, DIAGNOSIS AND TREATMENT DEMONSTRATION PROJECT

INTERIM EVALUATION REPORT

THROUGH JUNE 30, 1978

VOLUME II

Information
Resource
Center

EPSDT
6.39

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This is the second volume of a planned three-volume set describing and evaluating the Dade County EPSDT Demonstration Project. Readers are referred to Volume I, "Evaluation Report for the First Fiscal Year - July 1, 1976 to June 30, 1977".

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INTRODUCTION

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a preventive and corrective health care program for Medicaid-eligible children up to age 21. It is intended to be an entry mechanism into the health care system, to encourage and facilitate the use of community health care resources, to establish an awareness of the need for preventive medicine, and to assist in the discovery of actual and potential health problems in infants, children, and adolescents.

The Dade County, Florida, EPSDT Demonstration Project, one of several such projects located across the country, was approved and funded in 1976 under Section 15 of Title XI and Title XIX of the Social Security Act. The goal of the project is to develop and evaluate innovative techniques to bring the Medicaid-eligible child into the health care system, providing specific and reliable documentation and data on the effectiveness and cost of these techniques so as to bring about the establishment of health care and maintenance programs that are medically, socially, and financially effective.

In order to accomplish this goal, several major objectives have been conceived: to coordinate EPSDT and other related programs for the most effective and efficient utilization of community resources; to increase accessibility to the health care system by employing personal case management techniques, including evaluation of the effects of ethnicity on the success of case intervention;

Department for Health and Rehabilitative Services. Identification of eligible children is the responsibility of the Welfare Department which arranges for screening appointment with the Health Department (See Exhibit I-1 "Client Notification Form"). In Dade County, the Department of Health has subcontracted for screening services with the Comprehensive Health Care Program (CHCP), Community Health Incorporated (CHI), and the Family Practice Clinic. Although approximately 33,000 children in Dade County are eligible for screening, only 45% are taking advantage of the program. Obstacles to participation that are frequently cited include complexity of registration, inadequate communication, lack of transportation, inconvenient clinic operating hours, long delays in obtaining services, lack of understanding of the importance of preventive medicine, and production line techniques that damage the self-esteem of potential clients, thereby discouraging participation in available programs.

The purpose of the Dade County EPSDT Project, and others like it across the country, is to integrate the various aspects of the health care network, to increase accessibility to the system for the eligible child, and to encourage full participation to achieve the maximum potential of available services. Within the priorities established for the program, the Project is to develop, implement, and evaluate various techniques for achieving the desired results.

(Side 1)

Exhibit I-1

E.P.S.D.T. DEMONSTRATION PROJECT

CLIENT NOTIFICATION FORM

I understand that I am eligible to participate in the free, voluntary, health care program for my children, which includes a health examination and any treatment they may need for health improvement.

___ Yes, I am interested in participating in this Program.

___ No, I am not interested in participating at this time, but I understand that I may participate at a later time as long as I am eligible for Medicaid services.

CLIENT C.M. DATE

(Side 2)

E.P.S.D.T. DEMONSTRATION PROJECT

NOTIFICACION DE CLIENTE

Yo entiendo que tengo la oportunidad de participar en un programa de salud para mi(s) nino(s), el cual es voluntario y gratis y el que incluye un examen fisico y el tratamiento que sea necessario para la mejora de su salud.

___ Si, yo tengo interes en participar en este Programa.

___ No, yo no tengo interes en participar en este memento, pero you entiendo que en el futuro puedo participar siempre que reciba los servicios de Medicaid.

CLIENTE C.M. FECHA

Administration, Organization and Implementation

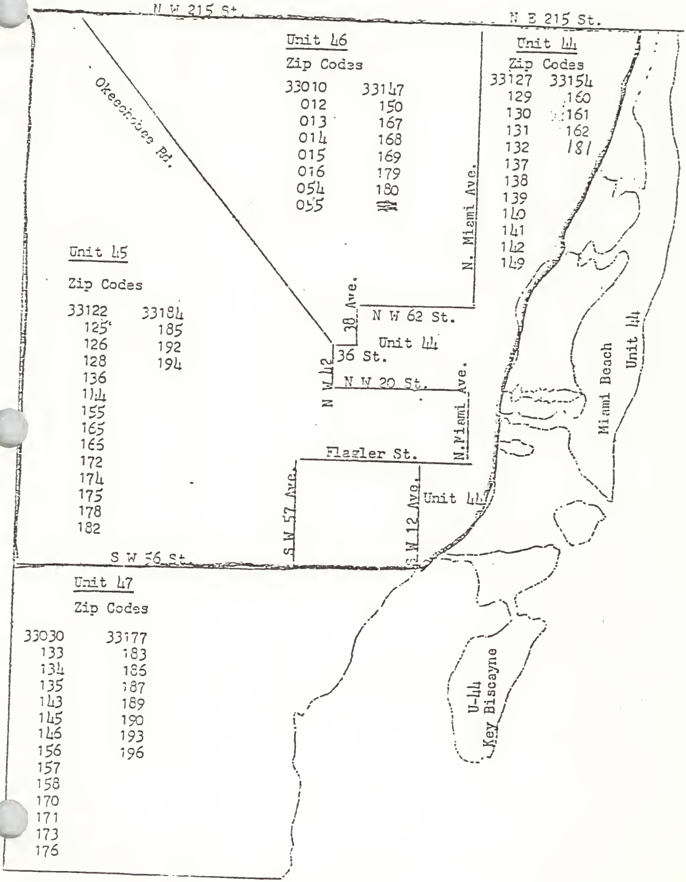
The first year of operation for the Dade County EPSDT Demonstration Project, Fiscal Year 1976/1977, was largely concerned with the administrative organization of the Project, acquisition and training of personnel, and the development of personal and contractual linkages with providers of health care services and related organizations throughout the community. Project activities included the formulation of goals and objectives and the development of a research design, the selection of developmental screening techniques, and the establishment of a relationship with the school system.

During the second year of the Project (Fiscal Year 1977/78), plans were put into operation. Each component evolved, and Project activity centered around implementation. As problems in the design were identified, suitable modifications were devised and implemented by Project Staff. The various problems and the subsequent revisions are discussed in detail in this report under each component area.

Project Site Selection and Target Population

The initial Project target area was selected on the basis of data from the 1970 census, with supplemental information (on Medicaid-eligible children and Medicaid services) provided by the HRS Office of Program Planning. The latter was obtained by means of computerized Medicaid eligibility and provider records for September 1976.

Map 1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N E 215 St.
Unit 46
Zip Codes
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Okeechobee Rd.
N. Miami Ave.
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38 Ave.
N W 62 St.
Unit 44
36 St.
N W 42
N W 20 St.
N. Miami Ave.
Flagler St.
S W 57 Ave.
S W 12 Ave.
Unit 44
S W 56 St.
Miami Beach
Unit 44
Unit 47
Zip Codes
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categorized as follows:

Group I: Persons who consider themselves to be members of the Black race. Blacks of Latin cultural heritage, however, would be included in the Spanish ethnic category.

Group II: Persons who consider themselves to be of Spanish heritage and culture. Blacks of Latin heritage would be included in this group.

Group III: Persons who consider themselves to be members of the White race and who do not consider themselves to be of Latin cultural heritage.

By the end of the second month of sampling (February 1977), it became obvious that the area would have to be expanded to include more Spanish (Group II) and White non-Spanish (Group III) AFDC families, since at that stage the Project caseload consisted of 88% Black, 10% Spanish, and 3% White non-Spanish.

The following criteria were established for area expansion as set forth in the research design:

1. The area must contain a sufficient number of Spanish Medicaid-eligible children to meet Project sampling quotas.

2. The area must contain a sufficient number of White non-Spanish Medicaid-eligible children to meet Project sampling quotas.

3. The area should be within a reasonable travel distance from the Project's base headquarters.

Organization of This Report

The purpose of this report is to summarize first year activities, explain modifications that took place in the Project design, and to evaluate the effectiveness of the Dade County E.P.S.D.T. Demonstration Project in its second year of operation (Fiscal Year 1977-1978: July 1, 1977 - June 30, 1978) as related to the stated goals and objectives. Since the Project has been conceptually divided into five program components, this evaluation will consider each area separately, detailing individual goals and objectives for each component and discussing progress to date in achieving the Project's aims. Data will be presented and discussed for the Project to date, from July 1, 1976 through June 30, 1978. Illustrative tables and exhibits will accompany the text.

The five major program areas under consideration, in order of discussion, are:

Case Monitoring
School Intervention
Developmental Screening
The Older Child
Interagency Collaboration

CASE MONITORING

I. Introduction and Progress in Fiscal Year 1976-1977

A. Statement of Goals and Objectives

The case monitoring component was designed to increase the knowledge of, and accessibility to, health care services available in the area through the use of case management techniques, and is basically a study of the effects of case intervention by Project case monitors on a sample of children whose parents or guardians have indicated an interest in E.P.S.D.T. screening. In this type of monitoring, the individual is assigned to a worker who then follows the client through the various stages of screening, diagnosis and treatment in order to ensure the integration of the eligible child into the health care system. Intervention by the worker may occur at any stage within the process in order to make certain that the child is receiving maximum services to meet his particular needs.

In accordance with the goals and functions of the case monitoring component, the following objectives were established:

1. To establish a mechanism to monitor Medicaid eligible children through the health care system.
2. To design techniques for training case monitors.
3. To develop and implement methods to stimulate parent

responsiveness and thereby achieve higher rates of case completion.

4. To create a management information system to document and process monitoring data.

5. To determine the incremental cost of case monitoring.

Since the intention of the program is to demonstrate whether or not personal intervention by case monitors will increase family participation in health care services in a timely manner, and if it is a cost-effective means of improving the health status of the young Medicaid-eligible population, the research objectives of this component of the Project consist of:

1. Comparing children receiving case intervention from Project Case Monitors (Experimental Condition) with children receiving E.P.S.D.T. support services from Social and Economic Services (Contemporary Control Condition and Historical Control Condition) in terms of:
    - a. Rates of shows for screening for all cases.
    - b. Rates of shows for the first diagnosis/treatment appointment for all cases with problems identified at screening.
    - c. Rates of problem resolution for each problem identified at screening or during the course of treatment.

d. Rates of completion for all cases.

2. Determining the incremental cost per cas of case intervention by Project case monitors, a d evaluating the cost in terms of:

a. Rate of problem resolution.

b. Rate of case completion.

B. Development of Monitoring and Interventi n System

Negotiations were conducted for total cor ract renewal and for new contractual agreements with various health care service centers in Dade County, and subcontracts for screening sites were established through th Dade County Public Health Department. In addition, comprehensive listing of all Medicaid providers and their cor esponding medical specialty areas was compiled. Staff re orted success in obtaining participation from provide s in the diagnosis and treatment components, but noted t at the most prevalent question raised by the providers conc rned the billing and reimbursement procedures.

By the second quarter of the fiscal year six case monitors were employed. Training sessions were developed to explain the functions, duties and responsibi lities of an effective case monitor. An informational ha dbook was developed and distributed to case monitors for urther study and future reference. In addition to thi method of introduction to the case monitoring component, ase monitors met with members of various community agencies with whom they would be in frequent contact. They were involved in a rotational placement at Social and Economic Services in order to develop a clearer understanding of the general system, Federal and State regulations, the State record keeping system, and to become familiar with the various interviewing techniques that were previously deemed effective.

Following the complete training procedure, monitors were assigned to two conditions: experimental and control, the control group being further subdivided into Contemporary Control and Historical Control. The case monitors remained active in the experimental condition by interacting directly with clients, while in the control condition their main function was data collection. By the end of the fiscal year in June 1977, the active caseload totalled 1,005.

Stimulation of parental responsiveness in order to achieve higher rates of case completion is still another objective of this component and was yet another function of the case monitors. They accomplished this task through successful attempts to remove some of the barriers and obstacles inherent in the system, including the following identified problems:

1. Eligibility and/or registration activities may be too complex and inconvenient, keeping eligible families from seeking screening service.

2. Adequate communication is often lacking between social service worker and family. Parents may not be aware of the purpose and importance of screening as well as the meaning of the test results. In addition, key instructions, including appointment times, may not be completely communicated to the patient and his/her parents.
3. Screening facilities often do not take into consideration the comfort and self-esteem of potential participants in the system.
4. Long distance travelling to providers of health care services, and the inability to arrange for transportation, often presents problems.
5. Inconvenient appointment times scheduled months in advance, and long delays in waiting for services, may discourage participation in screening.

C. Development of Management Information System

An important by-product of the Project's goal of devising case monitoring techniques to increase the accessibility to and participation in health care programs has been the development of a computerized management information system (MIS). The system presently in use was created specifically for the Dade County Demonstration Project by Project staff in collaboration with a data processing vendor in Coral Gables, Florida: Dynamic Control Corporation, Inc. The system has been designed for both management and analytical use, and is compatible with statewide reporting systems used by other public assistance programs.

The Central Processing Unit consists of an IBM System 3 Model 15 computer with one hundred twenty million bytes of on-line disc storage. The unit is located at the vendors facility, and the Project is billed monthly for its use. On-site terminals leased from IBM communicate with the central unit for remote site data entry and retrieval over a leased telephone line. The on-site hardware was installed in the Project offices in February 1977.

Two modes of on-line data access have been designed. The inquiry mode allows a specific case to be called upon on the terminal for review purposes. The edit mode permits changes in case data and entry of new information.

Four levels of security have been included in the system:

1. A unique 3-digit security code is used for the inquiry mode. This code is available only to Project staff.
2. A unique 3-digit security code, known only to persons who are authorized to enter or update data, is used for the edit mode.

Upon completion of the programming of the on-line entry of screening, diagnosis and treatment information, the MIS became fully operational. Other pertinent informationupdating and correcting of existing case records, determining problem status, entering time/activity information and presentation of background information - necessitated the development of more computer programs. These programs were successfully developed and, by the end of April 1977, all records and cases sampled since the beginning of the Project were updated. Case entry then proceeded on a current basis.

The development of standardized forms for data input was crucial for consistency and accuracy of data entry to prevail. Hence, three forms were designed to accomplish this as well as to permit direct entry of data into the system without requiring coding or keypunching.

The Registration Form provides background and administrative information on a case and is the first step in opening a case record. The case monitor is responsible for collecting the necessary data required to complete this form. His/her primary sources of information are: the SES caseworker, Medicaid registration files, and a personal interview with the client and/or the client's health decision maker.

The purpose of the other two forms, the Transaction Form and the Problem Referral Form, is to provide continuous update information, so the current status on each case is always available. In addition, these forms provide data for Project management by compiling information on the work and time expended by case monitors on case intervention. Eventually, this information will prove quite valuable in cost-benefit analyses of the case monitoring component.

Output data is available in two forms: hard-copy reports and magnetic tapes. Reports include the following materials.

1. Operating/Management Reports
    a. Weekly list of the current week's appointments for each case monitor.
    b. Weekly list of unresolved appointments.
    c. Monthly "exception report" for each case monitor, of cases with missing background data by condition.
    d. Monthly list of cases completed by each case monitor, sorted by condition.
    e. Monthly "exception report" for each case monitor of experimental group cases with unresolved problems.
    f. Quarterly report of completed cases sorted by condition, ethnic group and age.
    g. Quarterly report of incomplete cases sorted by condition, ethnic group and age.
2. Research Reports are provided monthly, which present:

a. Summary of time per case monitoring activity for each case monitor, in terms of total time per activity, total case load per activity, and average time per case activity.

b. Summary of time per case monitoring activity for all case monitors combined.

c. Time/activity analysis for each case monitor for all conditions combined in terms of total time per activity and total Project time.

d. Cost analysis by time and activity, with direct and indirect costs presented for each condition and for all conditions combined.

3. Data Verification Reports are printed weekly and include all transactions and case information entered that week.

In addition to these reports, the vendor will be providing the magnetic tapes on all completed cases semi-annually. The tapes will contain all background and case progress information, which will eventually be analyzed using a pre-programmed statistical package.

Prior to the implementation of the Management Information System, a manual system of filing case records was employed. With the advent of a fully operational MIS into the Project in May 1977, the Project intended to phase out the antiquated manual system. However, problems arose regarding data entry and retrieval which, taken with staff's reluctance to change, necessitated the simultaneous usage of the two systems until modifications to and acceptance of the new computerized system were accomplished.

Mechanical modifications were implemented during the last two months of the fiscal year, but discrepancies between the two systems remained. Recommendations to eliminate such discrepancies were as follows:

1. Data verification was to be incorporated as a regular and on-going activity.
2. Access to the system, both for inquiry and update purposes, had to be simplified.
3. Further modifications in the program had to be made so that the system would process data that it could not presently accept.
4. Case monitors had to be encouraged to use the system for inquiry purposes and weaned from dependence on written files and records. Therefore, an intensive training program in the use of computers was recommended for all case monitors.

D. Progress of Historical and Contemporary Control Group Samples

Although sampling began in January 1977, analysis data was not available until the end of the fiscal year, due to constraints imposed by the research design. Because it takes at least 4 months from the date of request to receive information regarding the screening and treatment outcome and appointment behavior, Contemporary Control Group interviews could not begin until May 1977 and in fact, did not begin until June 1977.

An acceptable method of obtaining comparative data for the Historical Control Group had not been devised by the end of the first fiscal year, although a questionnaire for client interview was drafted in April. One case monitor was assigned to the Historical case investigations. By the end of April, an interview questionnaire had been designed and approved for use with the Contemporary Group, and training sessions for monitors working with this group were held in May. As of the end of the fiscal year in June 30, 1977, 76 Historical Group cases and 499 Contemporary Group cases had been closed.

E. Problems Identified

During the first year, three major problems were identified in the case monitoring component which necessitated resolution for ultimate success.

A penetration rate of less than 50%, along with a poor rate of shows for appointments, was believed to be the result of such factors as a lack of information about the program on the part of those eligible for benefits;

a lack of communication among clients, caseworkers and health care providers; the complexity of registration procedures; and physical inconvenience of reaching testing and treatment sites. Elimination, or at least amelioration, of these significant deterrents was considered to be vital in obtaining the goal of increasing participation in the program.

It was apparent early in the Project that authority for non-emergency treatment in certain cases was another problem. Ten to twelve percent of children eligible for Medicaid benefits were living with individuals other than a parent or legal guardian. AFDC grants were awarded but the resident adult was not legally empowered to act for the child. This created difficulties because providers were reluctant to give non-emergency medical care without legal authorization. In response to this, the Project developed a procedure for petitioning the courts for authority for non-parent relatives to approve medical screening and treatment for children in their custody. As a result of the establishment of such a procedure, 18 children received medical care by the end of the first fiscal year.

The third problem that deserved attention was that of determining the optimum caseload for each case monitor. During the first fiscal year, the number of cases per case monitor was tabulated and the success/failure rate was recorded.

From the data collected thus far, it is difficult to determine the optimal number of cases per case monitor precisely. But this effect will be considered in greater detail through the duration of the Project when a more significant number of cases has been completed, when other independent variables (age, sex, ethnicity, etc.) are available for review, and when monitors have presumably acquired greater expertise in handling their cases. In any event it was agreed that caseloads should be continually adjusted until an optimal load appeared to have been reached, with all monitors achieving or approaching 100% kept appointments within 60 days.

II. Progress in Fiscal Year 1977-1978

A. Orientation for Case Monitors

During the fiscal year 1977-1978, more case monitors were employed. Project staff had noted the necessity of hiring bilingual case monitors to dispel any existing communication barriers between Latin clients and the Project. This criterion was taken into account in the employment process.

In September, 3 new case monitors began working. They attended the formalized 3-day training session and were then placed with previously trained monitors for 2 days to obtain "field experience". Subsequently, the new monitors were assigned to one of the 3 groups under study

(Experimental, Contemporary Control or Historical Control).

During the third quarter, the case monitors met with their supervisor to discuss those areas in which they felt inadequate. One commonly expressed difficulty lay in the area of listening and communication skills. During the following month a session was held to develop such skills through sensitivity training and role playing.

At the close of the first fiscal year, case monitors were involved in taking the Florida State Examination for Social Work Assistant positions, which prepared case monitors for classification of their staff positions under the State of Florida's Civil Service System.

Throughout the first two years of operation, the E.P.S.D.T. Demonstration Project experienced difficulty in the retention of case monitoring personnel. The only requirement for employment as a monitor was that the individual be able to follow both written and oral instructions. No degree of any kind was required. The State was not able to establish a career service position for Project monitors; they were considered temporary help and were categorized as "Other Professional Services" (OPS). This classification denotes:

1. No vacation pay
2. No sick leave
3. No paid holidays

4. No health insurance
5. Denial of participation in state retirement plan
6. No raises, either merit or cost of living

Finally, monitors were paid only at the entry level for their designated grade.

Case monitors left employ with the Project primarily because they received better job offers with more benefits and/or higher salary outside of the program.

Although one realized that the temporary nature of a demonstration project necessitated the State's OPS designation for its personnel, the need for stability in a program of this kind must be emphasized. The type of client who can be helped by the E.P.S.D.T. program depends on his or her case worker to negotiate the system. A high personnel turnover rate, with the resultant lack of continuity and diminished perception by the client of personal sympathy from the system, cannot help but have a negative effect on program success. Stricter requirements for the case monitor position must be developed and maintained, and permanent classification of the position on the State scale must be high enough to obtain the variety of benefits which can be utilized to attract and retain the most effective employees.

B. Authorization for Treatment in Absence of Parent

The procedures for authorization for treatment in cases where the legal guardian is not present continued to be utilized throughout the second year. Allowing the responsible adult to legally act for the child in non-emergency situations encouraged more individuals to take advantage of E.P.S.D.T. services. To date, 25 children have received medical care as a result of this procedure initiated by the Project.

C. Child Abuse Workshops

With the appearance of several cases of child abuse and/or neglect in the E.P.S.D.T. Project caseload, Project staff met with HRS personnel to gain a clearer understanding of state laws and regulations regarding child abuse. Because cases of abuse and/or neglect should be brought to the attention of the police, it was determined that active participation on the part of the Project was necessary in order to learn how these cases could be handled most effectively.

During the second quarter of the 1977/1978 fiscal year, child abuse workshops were developed by HRS personnel in conjunction with the Metropolitan Dade County Police Department. The purpose of these workshops was to train social workers and police officers in handling child abuse and neglect cases. Three workshops were planned: the first workshop to include 40-50 officers from 5 units of the Metro Dade County Public Safety Department; the second workshop designed for social workers; and the third to include all those who participated in the first two sessions to enable them to share experiences and discuss further any other difficulties that may have arisen.

Throughout January and February of 1978, the Project's Sector Coordinator continued her work on the development and planning of the workshops, cooperating closely with HRS personnel from Child Abuse units and with Metro Public Safety officers for further discussion and feedback.

The first child abuse workshop for police officers was held in March of 1978. The second and third sessions took place during the summer of 1978.

D. Provider Related Events

A shortage of Medicaid providers exists in various health areas in Dade County. As a result, the Project was involved in recruiting new providers for the Florida Medicaid system. During the second year alone, 27 new providers were recruited to furnish health care services previously unavailable to E.P.S.D.T. eligible children.

Project staff experienced some difficulty with certain Medicaid providers with regard to rescheduling of appointments.

Because they were rendering services for Medicaid eligibles at reduced rates, some providers refused to reschedule appointments for those clients who had previously failed to show up for a scheduled examination. The Project therefore made an effort to identify clients who repeatedly missed appointments and to discuss with them the importance of good appointment-keeping behavior. The Project also attempted to convince physicians to reschedule appointments. This method proved successful in most cases; in those instances in which it failed, another service provider was procured to attend to that client.

E. Health Education Techniques

Throughout the first two years of its operation, the Project encountered numerous Medicaid-eligible clients who failed to keep screening and treatment appointments because they did not understand the importance of E.P.S.D.T. services. It was felt, therefore, that case monitors could benefit from communication and effectiveness training to improve their interpersonal skills. An ad hoc committee of the Advisory Council was formed to deal with this program.

F. Problem of Incomplete Screening and Client Flow

Through careful review of screening data, it became evident that several screening clinics had extremely low screening completion rates. This was a result of unfinished screens of clients during a single visit. The Project Manager met with clinic directors to stress the importance of completing a screening in one visit. Statistical comparison clearly indicated that higher screening completion rates could be achieved if screening was conducted in only one visit; noting this, the clinic directors agreed to comply.

Another problem that needed attention was the reporting system for screening results. The Project Sector Coordinator held a meeting with the Chief of Medical Services of the Dade County Health Department, the Director of Social Services for CHCP, and the HRS General Services Supervisor to discuss the issue of how to expedite the reporting of screening results to the Health Department. It was additionally noted that these results had to be reported so that physicians could be reimbursed for diagnosis and follow-up treatment. At this meeting, 3 causes of reporting delay were identified:

1. At times it took as long as four weeks after a child had been screened to get necessary information entered into the HRS computer in Jacksonville.
2. It was very difficult to obtain a client transaction number because the phone lines at SES were constantly busy.
3. Screening results from scattered sites were not being transferred to the central coordinator at the Health Department in a timely manner.

The Health Department, which acts for the State in contracting various agencies to complete screens on Medicaid children in Dade County, agreed to review its screening contracts and to develop new reporting procedures for the subcontracting agencies. The intended results of these new reporting procedures would be to permit earlier diagnosis and treatment of problems discovered during screening.

G. Post Completion Treatment

The term "post completion treatment" refers to the situation in which Project clients reported to case monitors new health problems, or the reappearance of an old health problem, after the case had been officially closed by the Project. Since the Project was organized and funded on a temporary basis to treat specific methods of case handling, certain points were defined at which a case could be considered to be complete and in need of no further attention. On the other hand, a certain moral obligation to the client was perceived, in that one of the purposes of the Project was to provide a personal link between the system and the client through the case monitor; the Project did not want to discourage former clients from continued participation in health care programs. In addition, adjustments were required in computer programs to permit acceptance of such entries into the data bank. The category of "post completion treatment" was therefore created, including all those cases previously closed that were nevertheless in need of additional attention. Although clients in this category are no longer considered to be experimental cases, monitor time spent on such cases is still reported and computed in the case management time accounting system.

H. Management Information System

The computerized management information system was designed to collect three types of data:

1. Background information (e.g., name, address, ethnic group, etc.) collected prior to the beginning of monitoring. Data is extracted from State Welfare payment records and is used by case monitors to contact eligible families.
2. Medical and dental treatment information serves to track clients through the health care system. Case monitors have access to individual files containing all appointments.
3. The time accounting system relates to the amount of time expended on a case by a monitor. It will be used along with other indicators to determine the incremental cost per client of case monitoring.

During the second year of the Project, attempts were made to correct the inadequacies detected in the system and to refine data input and output.

One major problem was the duplication of information and collection of unnecessary information from existing forms. The original Registration Form was two pages long and was filled out for each family member. Hence, duplication of family information resulted. Also, the data from the registration forms was stored in six different locations in the computer which meant six displays were required to retrieve all the data, some of which was found to be unnecessary.

The existing Transaction Form also presented difficulties. Case monitors recorded their time data on this form along with client information. One transaction form was completed per client-related action thereby segmenting time accounting. This procedure was costly both in terms of increased processing time and in time spent verifying the accuracy of information. Also, since a separate transaction form was completed each time a monitor dealt with a client, many pieces of paper had to be processed and filed each day. As the amount of data to be processed increased, the amount of errors also increased.

Perceiving an immediate need to revise procedures, in September 1977 the forms were shortened and simplified, thus increasing efficiency. The number of questions on the Registration Form was reduced to gather all needed information for a single family on a one-page form. This effectively reduced the number of computer displays for background information from six to two. The transaction form was simplified to report only data pertinent to the Project's needs, and up to 12 clients could be included on a single form. This action alone dramatically reduced the flow of paper through the system. The time accounting system was also revised - instead of tracking time on the transaction form, each monitor was asked to complete a daily time sheet, allocating her activities to eight specific categories (See Exhibits CM-1 and CM-2 for original and revised Registration Forms, Exhibits CM-3 and CM-4 for original and revised Transaction Forms, and Exhibit CM-5 for revised timesheet).

A problem with the computer output reports was also detected by the end of the first year. Because of the untimely scheduling of reports and the deletion of information, time-consuming manual cross-checks were necessary. To resolve this problem, the MIS components were redesigned to include all classifications of cases on the same report. This procedure eliminated the need for manual cross-checking. Data verification was incorporated into the system as an ongoing daily activity. Reports were made available daily via a remote entry terminal to improve access by case monitors, and they included:

1. All cases with open appointments for that day.
2. All cases with open appointments for the next day.
3. All "past due" appointments which had not been followed up.

Exhibit CM-1

E.P.S.D.T. DEMONSTRATION PROJECT

==============================REGISTRATION FORM==============================

1 CHILD

MEDICAID NO.
☐☐☐☐☐☐☐ - ☐☐☐

1. INITIAL
2. UPDATE ☐

DATE OF REGISTRATION
☐☐ - ☐☐ - ☐☐

NAME
LAST FIRST M.I.

DATE OF BIRTH
☐☐ - ☐☐ - ☐☐

SEX ☐

ADDRESS
NO. STREET APT.#

PLACE OF BIRTH

CITY ZIP

ETHNIC GROUP ☐

ETHNICITY CODE ☐☐

GROUP CODE ☐

SCHOOL INTERVENTION ☐

PHONE NUMBER FOR CONTACT:
☐☐☐ - ☐☐☐☐

CENSUS TRACT
☐☐☐ . ☐☐

SCHOOL ☐☐☐
NAME CODE

---

2 HEALTH DECISION MAKER (CHECK ONE):

MOTHER ☐
FATHER ☐
SELF ☐

SOURCES OF MEDICAL CARE (CHECK BOX OR BOXES):

HEALTH DEPT. - DOWNTOWN ☐
HEALTH DEPT. - 46 STREET ☐
CHCP ☐
FAMILY HEALTH CENTER ☐
CLINICA BORINQUEN ☐
JACKSON (SPECIFY UNIT) ☐
PRIVATE PROVIDER (SPECIFY) ☐
OTHER (SPECIFY) ☐

SOURCES OF FAMILY INCOME (MONTHLY):

EARNED INCOME $ ☐☐☐
OTHER INCOME ☐☐☐
SOCIAL SECURITY ☐☐☐
AFDC GRANT ☐☐☐

SOURCES OF MEDICAL PAYMENTS (CHECK BOX(S):

MEDICAID ☐
CASH ☐
INSURANCE ☐
FEDERAL PROJECT ☐
OTHER (SPECIFY) ☐

HEAD OF FAMILY (CHECK ONE):

MOTHER ☐
FATHER ☐
GRANDPARENT ☐
OTHER RELATIVE ☐
OTHER ☐

REGISTRATION FORM - PAGE 2

3 | MOTHER

PHONE # FOR CONTACT

☐☐☐ - ☐☐☐☐

LAST FIRST MI.

WORK ☐☐☐ - ☐☐☐☐

ADDRESS
(IF DIFFERENT
FROM CHILD) NO. STREET APT.#

CITY ZIP

DATE OF BIRTH

☐☐-☐☐-☐☐

PLACE OF BIRTH:

CURRENTLY EMPLOYED YES ☐ FULLTIME ☐

NO ☐ PARTTIME ☐

PRIMARY LANGUAGE: ☐

DATE OF EMPLOYMENT: ☐☐-☐☐-☐☐

ETHNIC GROUP ☐

OCCUPATION CODE ☐☐☐☐

ETHNICITY CODE ☐☐

EDUCATION (YRS): ☐☐

RELATIONSHIP TO CHILD ☐

4 | FATHER

PHONE # FOR CONTACT

☐☐☐ - ☐☐☐☐

LAST FIRST MI.

WORK ☐☐☐- ☐☐☐☐

ADDRESS
(IF DIFFERENT
FROM CHILD) NO. STREET APT.

CITY ZIP

DATE OF BIRTH

☐☐- ☐☐- ☐☐

PLACE OF BIRTH:

CURRENTLY EMPLOYED:

PRIMARY LANGUAGE: ☐

DATE OF EMPLOYMENT: ☐☐- ☐☐- ☐☐

ETHNIC GROUP ☐

OCCUPATION CODE ☐☐☐☐

ETHNICITY CODE ☐☐

EDUCATION (YRS.): ☐☐

RELATIONSHIP TO CHILD ☐

5

REFERRAL DATE ☐☐ - ☐☐ - ☐☐

REFERRAL CODE ☐

APPLICATIONS UNIT ☐☐

PAYMENTS UNIT ☐☐

SERVICE UNIT ☐☐

CASE MONITOR:

NAME CODE ☐☐

MEDICAID ELIGIBILITY

CODE	DATE
☐	☐☐-☐☐-☐☐
☐	☐☐-☐☐-☐☐
☐	☐☐-☐☐-☐☐

6

NUMBER OF OTHER CHILDREN RECEIVING MEDICAID ☐

MEMBER NO.	DATE OF BIRTH	RELATIONSHIP CODE
☐☐☐	☐☐-☐☐-☐☐	☐
☐☐☐	☐☐-☐☐-☐☐	☐
☐☐☐	☐☐-☐☐-☐☐	☐
☐☐☐	☐☐-☐☐-☐☐	☐
☐☐☐	☐☐-☐☐-☐☐	☐
☐☐☐	☐☐-☐☐-☐☐	☐
☐☐☐	☐☐-☐☐-☐☐	☐
☐☐☐	☐☐-☐☐-☐☐	☐

Exhibit CM-2

E.P.S.D.T. DEMONSTRATION PROJECT
REGISTRATION FORM

1 FAMILY: HDM

MEDICAID NO. ☐☐☐☐☐☐☐

1. INITIAL ☐
2. UPDATE ☐

DATE OF REGISTRATION ☐☐ ☐☐ ☐☐

NAME ____________________
last first mi.

DATE OF BIRTH ☐☐ ☐☐ ☐☐

SEX ☐

ADDRESS ____________________
no. street apt#

____
city state zip

____
place of birth

ETHNIC GROUP ☐

PHONE ☐☐☐ ☐☐☐☐

ETHNICITY CODE ☐☐

PAYMENTS UNIT ☐☐

EDUCATION (YRS) ☐☐

SERVICE UNIT ☐☐

CASE MONITOR ____________ ☐☐

CHILDREN

NAME last first mi.	MEMBER NO.	DATE OF BIRTH	RELATIONSHIP TO HDM
____________________	☐☐☐	☐☐ ☐☐ ☐☐	☐
____________________	☐☐☐	☐☐ ☐☐ ☐☐	☐
____________________	☐☐☐	☐☐ ☐☐ ☐☐	☐
____________________	☐☐☐	☐☐ ☐☐ ☐☐	☐
____________________	☐☐☐	☐☐ ☐☐ ☐☐	☐
____________________	☐☐☐	☐☐ ☐☐ ☐☐	☐

2 CHILD

MEDICAID NO. ☐☐☐☐☐☐☐ ☐☐☐

DATE OF REGISTRATION ☐☐ ☐☐ ☐☐

SEX ☐

NAME ____________________
last first mi.

____
place of birth

ETHNIC GROUP ☐

REFERRAL DATE ☐☐ ☐☐ ☐☐

ETHNICITY CODE ☐☐

PREVIOUS SOURCES OF MEDICAL
CARE ____________________

SCHOOL ____________________ ☐☐☐

SCHOOL INTERVENTION ☐ yes ☐ no

REV 1177

E.P.S.D.T. DEMONSTRATION PROJECT

TRANSACTION FORM

MEDICAID NO.

☐☐☐☐☐☐☐ - ☐☐☐

CHILD'S NAME ____________________

DATE ☐☐ - ☐☐ - ☐☐

CASE MONITOR ____________________ CODE ☐☐

SER-VICE	FUNC-TION	MODE	DIS-PLAY	TIME (Min.)	PERSON CONTACTED/ACTIVITY ACCOMPLISHED	DATA BASE UPDATE (INFORMATION FOR COMPUTER)

SERVICE CODES:

1. Education
2. Appointment Scheduling
3. Information
4. Transaportation
5. Training

FUNCTION CODES:

1. Case Management
2. Screening
3. Diagnosis/Treatment
4. Research
5. Post-Completion Treatment

MODE CODES:

1. Phone Call
2. Office Contact
3. Outside Contact
4. Records

DISPLAY CODES:

01 Child
02 Family-Medical
03 Mother
04 Father
05 Referral-Medicaid
06 Other Children
09 Administration
10 Screening
20-99 Medical Problems (See List)

Exhibit CM-3

TRANSACTION FORM - PAGE 2

MEDICAID NO.

☐☐☐☐☐☐☐ - ☐☐☐

DISPLAY CODE	INFORMATION FOR COMPUTER

E.P.S.D.T. DEMONSTRATION PROJECT

TRANSACTION FORM

________________ ☐☐ CASE MONITOR

DATE ☐☐-☐☐-☐☐

MEDICAID #	NAME last, first	DISPLAY	DATA	SCREENING/ PROBLEM STATUS	COMPUTER ENTRY

REV 1277

Exhibit CM-4

Exhibit CM-5

E.P.S.D.T. DEMONSTRATION PROJECT

CASE MONITOR DAILY TIME SUMMARY SHEET

________________ ☐☐
CASE MONITOR

DATE ☐☐ ☐☐ ☐☐

MAJOR ACTIVITY	TIME WORKED TODAY	
	HOURS	MINUTES
Case Management (Experimental Only)	____	____
Training (including Briefings and Staff Meetings)	____	____
Historical Control	____	____
Contemporary Control.	____	____
Developmental Case Support Services	____	____
Personal (including breaks)	____	____
Administrative.	____	____
Other Specify	____	____
________________________________	____	____
TOTAL TIME WORKED TODAY	____	____

4. All open cases with no recorded outstanding screening or treatment appointments.

This daily report of activity was tied into the time accounting system for automatic calculation monthly of the mean number of hours required to close a case by case monitor.

Further modifications to the system took place during the second year of operation. The primary objectives of these refinements were as follows:

1. To obtain a higher accuracy rate on the data collected
2. To increase efficiency of data collection and entry
3. To reduce the amount of paperwork required of data clerks and case monitors
4. To reduce the amount of computer space required for each case record
5. To collect only useful data
6. To increase the management capabilities of the system.

A notebook containing all necessary revisions in detail was compiled and was delivered to the computer subcontractors, Dynamic Control, for necessary reprogramming. These revisions included:

1. Case monitor sign-in each morning.
2. Response by computer, through a presentation of a series of displays, detailing the separate components of case monitor workload for that day.

3. Record of sign-in time which the supervisor received in the form of a monthly report.
4. Monthly calculation of "average" case monitor hours required to service the "average" case.
5. Number and rate of screening completions each month for each case monitor.
6. Weekly report of all open cases which had no outstanding appointments.

By mid May 1978, the programming was completed and a prototype of the revised system, along with a copy of the Project's data base, was placed in the computer in a "test file". The test file provided the Project with the opportunity to correct any errors before actual implementation of the modified system occurred.

During the first fiscal year of the Project, it had been noted that case monitors continued to rely heavily on their manual filing system. Although this method was more time consuming, the monitors apparently had more confidence in the paper system. Because of the self-defeating nature of this situation, Project management determined that it was imperative for case monitors to become proficient in the use of the computer, not only for purposes of testing the value of automated record-keeping but also to expedite the case monitoring process. Following a brief but intensive orientation and training program, the case monitors were surveyed regarding their attitude toward the use of the computer. With a more complete understanding of the components and capabilities of the system, and given ample opportunity to practice procedures, all monitors reported that they were much more comfortable with the automated system and that they considered their access to case records to have been greatly improved.

I. Historical and Contemporary Control Groups

Client interview, the original procedure for data collection for the Historical and Contemporary Control Groups, was deemed unsatisfactory once put into use due to incomplete and inaccurate information. Approximately 50 health decision makers were asked the following questions:

1. When and where was your child screened?
2. What was the outcome?
3. If treatment was needed, was it provided and where?
4. What was the treatment outcome?

The problem with this method of data collection lay primarily in the time differential between the screening, treatment, and interview dates. Clients had difficulty in recalling accurately all the information requested. Project staff therefore searched for alternate methods of data collection.

The Project's Research Assistant found that some screening information on Medicaid eligibles who participated in the E.P.S.D.T. Project could be extracted from HRS computer records. This provided the Project with such information as who was screened and on what day the screening took place.

The Dade County Health Department was then able to supply the Project with the remaining screening information, including the place of screening and the screening results.

As for collection of treatment data, again an avenue other than client interview was discovered. It was found that the Income Maintenance Section of Health and Rehabilitative Services in Tallahassee housed much of the necessary treatment information. By sending the child's name, Medicaid number, and date of screening to Tallahassee, the Project could receive the Medicaid payment records for each client. From this information, it could be determined whether treatment was given and the name of the provider of the service. The providers could then be contacted and, from their records, patient information (such as the nature of the problem treated and the date of treatment) could be extracted.

In summary, the new method of data collection proved to be much more effective in terms of accuracy and completeness. Information was obtained from state and provider records, and all required data was readily available. Hence, all questions were answered thoroughly. Also, eliminating the need for personal client interviews reduced the amount of time case monitors spent on each control case, thereby lowering the cost of the collection of control data.

By the end of the second fiscal year, a total of 1,188 clients were involved in control group sampling. Ethnicity was approximately 51% Black, 38% Spanish and 11% White non-Spanish. These figures correlated closely with the ethnicity percentage in the experimental group. Performance data on the control groups, including comparative analysis with the experimental condition, will be presented in the evaluation report for the third and final year of the demonstration project.

III. Presentation and Analysis of Experimental Group Data

A. Definition of Analytical Terms

For purposes of this analysis, a closed case is defined as one for which the screening process has been concluded, either successfully or unsuccessfully, and if successfully, all problems identified in a particular client have been resolved. As strictly defined by the research design, a successful screening outcome implies that screening took place within sixty days of referral to the Project, or that the client had been previously screened prior to referral to the Project but still within the eligibility period. An unsuccessful screening outcome, or screening failure, is a case in which the client cannot be located or has missed 3 consecutive screening appointments. A screening failure also includes those clients who were screened more than 60 days after referral to the Project. Clients who refuse services, who have moved from the area, or who have otherwise lost their eligibility for Medicaid services since the date of referral, will not be counted in the analytical sample. Total success or failure in achieving screening for all eligible clients will be reported, regardless of whether or not screening was concluded within the specified sixty day period.

In the second area of analysis (problem resolution) a success includes those cases in which (1) treatment has been completed, (2) a condition has been noted but treatment not advised at this time, or (3) no problems were identified at screening and the case therefore closed immediately. A failure includes clients for whom problems were identified at screening but who cannot be located for treatment or who miss three consecutive treatment appointments. As in the analysis of screening outcome, clients who refuse treatment, or who lose eligibility subsequent to sampling, will not be counted in the analysis.

B. Description of Sample:

As of the end of the fiscal year 1977/1978, 1,698 cases were closed. Children in the sample covered the entire age range of eligibility, from newborn to 20 years. Approximately 49% of the subjects were male and 51% female. Ethnicity was approximately 50% Black, 40% Spanish and 10% White non-Spanish. Case sampling began in January 1977 and continued through June 1978. Data was collected from seven health facilities located in Dade County, Florida. Of the total of 1,698 cases closed, 676 clients or 40% of the sample had problems identified, for a total of 935 separate problems.

C. Caseload Analysis:

An average of six monitors were involved in the case intervention process at any one time during the second fiscal year of the Project, with a total of ten employed since the start of case sampling in January 1977.

The total mean active caseload for all monitors was 253 cases. The mean number of open problems was 50.

As shown in Table CM-1, total success rate for all case monitors in the area of screening completion was 50.2%. Total success of case completion was 42.7%. Monitor 5, carrying the largest caseload, surpassed the total percentage of success in both screening and case completion but she was not the highest among monitors. Monitor 3, with only 10.9% of the total number of cases had a 69.3% success rate in screening completion and a 58.5% successful case completion rate. Although this monitor ranked fourth in the overall number of cases, she had the highest rate of success of those monitors carrying caseloads greater than 8.0% (an arbitrary figure

TABLE CM-1

ANALYSIS OF SUCCESS RATE OF SCREENING AND CASE COMPLETION BY CASE MONITOR

Monitor	% of Total Cases	% OF SUCCESS	
		Screening Completion	Case Completion
1	5.0 %	75.6 %	68.3 %
3	10.9	69.3	58.5
4	1.0	56.3	56.3
5	25.7	51.2	46.1
7	22.5	55.3	46.2
10	2.7	53.3	46.7
11	15.2	28.9	20.5
12	8.6	42.6	39.0
13	7.0	35.7	30.2
17	1.4	47.8	18.2
TOTAL	100 %	50.2	42.7

chosen for examination purposes only). Monitor 7, whose caseload totalled 22.5% of the sample and who ranked second in number of cases, had a successful screening completion rate of 55.3% and a case completion rate of 46.2%.

Table CM-2 presents us with an analysis of treatment completion rates for each case monitor. The total successful treatment completion rate for all case monitors was 74.9%. All case monitors with the exception of Monitor 11 performed above the 74.9% total rate of success: Monitor 7, who carried 19.4% of the total number of problems identified (hereafter referred to as "problemload") and again ranking second in the overall load, had a rate of success of 77.3%, the same as Monitor 1, who carried only 8.5% of the total problems identified. This success rate was the highest of all those monitors carrying problemloads of greater than 8.0%. Monitor 5, who had the largest caselaod, also had the largest problemload. Her success rate was 76.5%, second only to Monitors 1 and 7.

This analysis suggests that Monitors 5 and 7 performed most effectively. Their case/problem loads varied somewhat from each other, as did their success rates, but they both ranked among the highest in all three areas: screening, treatment and case completion.

As one can see from Table CM-1, caseload clearly differed between monitors. This was primarly due to the various monitors' effectiveness with their clients and to the high turnover rate among Project personnel.

TABLE CM-2

ANALYSIS OF SUCCESS RATE OF TREATMENT COMPLETION BY CASE MONITOR

Monitor	% of Total Problems Identified	% Successful Treatment Completion
1	8.5 %	77.3 %
3	14.4	75.8
4	1.6	78.6
5	24.9	76.5
7	19.4	77.3
10	2.3	85.0
11	12.6	61.6
12	7.1	76.2
13	8.3	75.7
17	0.9	75.0
TOTAL	100 %	74.9

D. Optimum Caseload

A single calculation for generalized optimum caseload across case monitors is possible to compute but not very meaningful, and may in fact be dysfunctional when put into use. Each monitor works at a different pace and must deal with a variety of client behaviors, but this does not mean that monitor caseload is not an important factor that deserves attention. A worker-specific optimum caseload can be calculated during each monitor's employment. The case monitor supervisor receives a weekly computer report presenting the monitor's caseload and performance. From this report, the supervisor can keep increasing or decreasing each monitor's workload until the success rate reaches a peak. At this point , the optimum caseload is attained.

It must be understood that, although there is no minimum caseload number, the supervisor still uses her own judgment to determine whether or not a monitor is performing adequately.

Using a worker-specific optimum caseload should not in any way affect a comparison among monitors. Instead of judging effectiveness on the basis of caseload, the supervisor utilizes percentage of success/failure for comparison purposes.

E. Screening Outcome

As presented in Tables CM-3 and CM-4, 1,928 clients requested screening. Two hundred fourteen (214) refused services or lost eligibility,leaving 1,714 cases to be adjudged

TABLE CM-3

SCREENING OUTCOME

CATEGORY	# OF CASES
REFUSED SERVICES	94
MOVED/LOST ELIGIBLITY	120
MISSED THREE APPOINTMENTS	118
CANNOT LOCATE	181
SCREENED WITHIN 60 DAYS	823
SCREENED AFTER 60 DAYS	224
OPEN MORE THAN 60 DAYS	81
PREVIOUSLY SCREENED	179
OPEN LESS THAN 60 DAYS	105
MISSING CASES	3
TOTAL	1928

TABLE CM-4

SCREENING COMPLETION RATE
IN 20 DAY INCREMENTS

DAYS	# OF CASES
0 - 20	148
21 - 40	422
41 - 60	253
61 - 80	111
81 - 100	60
101 - 120	18
121 - 140	5
141 - 160	11
MORE THAN 160 DAYS	19
	1047

successful or unsuccessful. Because those who were previously screened (179) received no screening services from the Project, these cases were also deducted from the sample. Of the 1535 remaining cases, 1047 or 68% completed screening: 823 (54%) within 60 days and 224 (14%) in more than 60 days. Two hundred ninety nine(299) clients (19% of the sample) missed three appointments or could not be located. The remaining cases (189) were still considered to be open at the end of the fiscal year. Therefore, according to the criteria established in the research design, the Project achieved a success rate in screening of 61%. Five hundred twenty three clients either were not screened or were screened more than 60 days after referral to the Project, for a failure rate of 39%.

The mean number of days from client request to be screened to screening completion was 46.6 days, with a standard deviation of 35.8 days. The screening period ranged from a minimum of 5.0 days to a maximum of 378.0 days.

F. Effect of Selected Variables on Screening Completion Rate

A number of variables were analyzed to see if any relationship existed among any of them and screening completion. A signficant relationship was found to exist between screening completion and the variable "Relationship of Client to Health Decision-Maker" (see Table CM-5). It was noted that, when the Health Decision-Maker was the client's grandparent, the success

TABLE CM-5

SCREENING COMPLETION RATE
BY RELATIONSHIP OF CLIENT TO HEALTH DECISION-MAKER

RELATIONSHIP	% OF TOTAL IN SAMPLE	% SUCCESS
CHILD	86.9%	50.2%
GRANDCHILD	3.8%	59.7%
SELF	6.6%	39.4%

rate rose to nearly 60%. The success rate with a parent as the Health Decision-Maker was 50.2%, while in the circumstance of the client being his/her own Health Decision-Maker the success rate for screening completion dropped sharply to 39.4%.

Ethnicity was another variable observed (see Table CM-6). For Blacks, who comprised 49.3% of the sample, successful screening completion rate was 59.2%. The Spanish sample totalled 41.8%, with a success rate of 41.1%. Whites, who made up only 8.9% of the sample,had a 42.5% screening completion success rate.

The agency at which the client initially requested services was found to be another important variable, as depicted in Table CM-7. It was found that the 33.8% of the sample who went to a Cuban Refugee Agency achieved a screening success rate of only 40.8%, while the 66.2% of the sample who requested services at Social and Economic Services achieved a successful screening completion rate of 54.6%.

A comparison of Spanish versus non-Spanish clients with a further division of "Spanish" into "Cuban" and "non-Cuban", was also found to hold significance. Cubans, non-Cuban Spanish, and non-Spanish were compared in terms of their successful screening completion rate, as shown in Table CM-8. Cubans comprised 33.8% of the sample and attained a successful screening completion rate of 40.8%. Other Spanish clients (8.5% of the total sample) experienced a 42.8% success rate for screening completion. Non-Spanish clients made up 57.7% of the sample

TABLE CM-6

SCREENING COMPLETION RATE
BY ETHNIC GROUP

ETHNIC GROUP	% OF TOTAL IN SAMPLE	% OF SUCCESS
BLACK	49.3 %	59.2 %
SPANISH	41.8 %	41.1 %
WHITE	8.9 %	42.5 %

TABLE CM-7

SCREENING COMPLETION RATE

BY AGENCY

AGENCY	% OF TOTAL	% SUCCESS
CUBAN REFUGEE AGENCY	33.8 %	40.8%
SOCIAL & ECONOMIC SERVICES	66.2%	54.6%

TABLE CM-8

SCREENING COMPLETION RATE
BY SPANISH TYPE

SPANISH TYPE	% OF TOTAL	% SUCCESS
CUBANS	33.8 %	40.8 %
OTHER SPANISH	8.5 %	42.8 %
NON-SPANISH	57.7 %	56.4 %

and had the highest successful screening completion rate of the three, 56.4%.

When the remaining variables - child age and sex, sex of Health Decision-Maker, and education level of Health Decision-Maker were analyzed, no significance was found to exist. These variables do not appear to affect screening completion rate.

G. Problem Resolution Status

Of the 1698 cases closed during the first two fiscal years, 676 involved the identification of one or more problems. In all, 935 problems were identified. Of these, 830 problems were resolved (either successfully or unsuccessfully), 59 refused services or lost eligibility, 13 were still under treatment, and 33 remained open and unresolved at the end of the fiscal year (see Table CM-9).

A successful problem resolution was defined to include one of the following three conditions: (1) problem identified and treated; (2) problem identified but treatment not advised at this time; or (3) no problem identified. Under this definition, 736 problems or 88.7% were successfully resolved. Unsuccessful problem resolution included those cases in which the client could not be located or missed 3 consecutive appointments. Of the 830 problems resolved, 94 fell into this category. The problem resolution failure rate therefore stood at 11.3%.

The types of problems encountered have been generally grouped into the following categories: dental; visual; hearing; nutrition; incomplete immunizations; neurological/developmental;

TABLE CM-9

STATUS OF PROBLEM

CATEGORY	# OF PROBLEMS
OPEN	33
REFUSED SERVICES	28
LOST ELIGIBILITY	31
MISSED 3 APPOINTMENTS	58
CANNOT LOCATE	36
STILL UNDER TREATMENT	13
FALSE POSITIVE SCREENING	10
CONDITION NOTED	19
TREATMENT COMPLETED	707
TOTAL	935

general medical/surgical (dermatological, respiratory, heart and circulatory, etc.);and general non-medical/surgical (such as psychiatric problems, emotional disorders, indicator of child abuse, and all others not fitting into one of the other categories). As shown in Table CM-10 dental problems comprise by far the greatest number (61%), followed by general medical/surgical (18.6%), and vision (17.4%).

H. First Show for Treatment

Of the 672 clients who had positive screening results, 545 or 81% showed up for their first treatment appointment. Five hundred sixteen (516) clients showed up for treatment within 60 days of screening completion. This is 77% of those who had positive screens, or 95% of those who showed up for treatment.

The mean number of days from screening completion to first show for treatment was 22.7 with a standard deviation of 20 days. The range of days from screening completion to first show for treatment extended from 0 to 141 (see Table CM-11).

I. Effect of Selected Variables on Treatment Completion Rate

Several variables were examined in order to determine the effects on treatment completion rate.

The relationship of the client to the Health Decision-Maker was observed (see Table CM-12). In cases where the client was the child of the Health Decision-Maker (83.4% of all problems),

TABLE CM-10

TYPES OF PROBLEMS

	% OF TOTAL PROBLEMS	% OF SUCCESS
DENTAL	61.0 %	73.2 %
VISUAL	17.4 %	79.2 %
HEARING	0.8 %	85.7 %
INCOMPLETE IMMUNIZATION	2.0 %	77.8 %
MEDICAL	18.6 %	75.8 %
PSYCHIATRIC	0.2 %	50.0 %
TOTAL	100. %	

TABLE CM-11

TIME FROM SCREENING COMPLETION TO 1st SHOW FOR TREATMENT IN 20 DAY INCREMENTS

DAYS	# OF CASES
0 - 20	308
21 - 40	170
41 - 60	38
61 - 80	12
81 - 100	8
101 - 120	7
121 - 140	1
141 - 160	1
TOTAL	545

TABLE CM-12

TREATMENT COMPLETION RATE
BY RELATIONSHIP OF CLIENT TO HEALTH DECISION-MAKER

RELATIONSHIP	% TOTAL	% SUCCESS
CHILD	83.4 %	73.5 %
GRANDCHILD	6.0%	92.5 %
SELF	6.9 %	77.0 %

the success rate was 73.5%. Grandchildren comprised 6.0% of the sample, but experienced a success rate of 92.5%. When the client served as his/her own Health Decision-Maker (6.9% of sample), the success rate totalled 77.0%.

Ethnicity was also found to show significance. Blacks, comprising 54.9% of the total sample, had a treatment success rate of 74.7%. White non-Spanish clients experienced the highest rate of success in treatment completion (88.9%), while making up only 8.1% of the total sample (see Table CM-13).

Again, the effect on successful treatment completion of the referring agency (Cuban Refugee Agency vs. SES) was observed. It was found that although the Cuban Refugee Agency had less than one-third the number of problems coming through their agency, their success rate was 69.1%, as compared to the 54.6% successful treatment completion rate of SES with two-thirds of the problems (see Table CM-14).

Cubans comprised 31.0% of the sample and had a 69.1% successful treatment completion rate. Other Spanish comprised only 6.8% of the sample and experienced a success rate of 84.7%. Non-Spanish, accounting for 62.2% of the total sample, had a success rate of 77.2% (see Table CM-15).

As was noted in screening completion, child age and sex, sex of Health Decision-Maker, and education level of Health Decision-Maker, were found to have no bearing on the treatment completion rate.

TABLE CM-13

TREATMENT COMPLETION RATE
BY ETHNIC GROUP

ETHNIC GROUP	% TOTAL	% SUCCESS
BLACK	54.9 %	74.9 %
SPANISH	37.0 %	72.0 %
WHITE	8.1 %	88.9 %

TABLE CM-14

TREATMENT COMPLETION RATE

BY AGENCY

AGENCY	% TOTAL	% SUCCESS
CUBAN REFUGEE AGENCY	31.0 %	69.1 %
SOCIAL & ECONOMIC SERVICES	66.2 %	54.6 %

TABLE CM-15

TREATMENT COMPLETION RATE
BY SPANISH TYPE

SPANISH TYPE	% TOTAL	% SUCCESS
CUBAN	31.0 %	69.1 %
OTHER SPANISH	6.8 %	84.7 %
NON-SPANISH	62.2 %	77.2 %

J. Case Completion Status

As defined in the research design, completed cases include all those clients for whom screening has been concluded (either successfully or unsuccessfully) and for whom at least one of the problems identified at screening have been resolved. Only one problem per client must be resolved for case completion to be judged a success or failure, but all problems identified at screening must be resolved before a case can be considered complete (closed). A negative screen (one in which no problems were identified) results in immediate case closure. The success or failure of such a case is determined by the success or failure of the screening phase above.

As shown in Table CM-16, 1698 cases were completed during the Project's first two years. In determining "success" and "failure", those clients who refused services or lost eligibility, and those who were screened prior to the start-up date of the Project, were dropped from the sample, leaving 1303 cases. Of these, 357 or 27.4% were considered failures and 946 or 72.6% were successfully concluded.

K. Effect of Selected Variables on Case Completion Rate

A number of variables were observed to determine what effect they may have on successful case completion rate.

As noted in Table CM-17, relationship of client to Health Decision-Maker was found to be a significant variable. Although

TABLE CM-16

CASE STATUS SUMMARY

	TOTAL # OF CASES COMPLETED	REFUSED SERVICES/ LOST ELIGIBILITY	PREVIOUSLY SCREENED	TREATMENT COMPLETE	NO PROBLEM	MISSED[3] APPT'S	CANNOT LOCATE
N	1698	252	143	577	369	156	201
%	100%	15%	8%	34%	22%	9%	12%

TABLE CM-17

CASE COMPLETION RATE

BY RELATIONSHIP OF CLIENT TO HEALTH DECISION-MAKER

RELATIONSHIP	% TOTAL	% SUCCESS
CHILD	86.8 %	42.4 %
GRANDCHILD	3.9 %	56.3 %
SELF	6.6 %	33.0 %

the client as a grandchild accounted for only 3.9% of the sample, such clients demonstrated the highest success rate: 56.3%.

Ethnic group was another variable observed. Blacks, comprising the largest part of the sample (49.8%) experienced a success rate of 51.8%. Spanish clients, making up 41.7% of the sample, showed the lowest success rate of the three (33.0%) (see Table CM-18).

Such variables as the gender of the Health Decision-Maker, as well as his/her level of education, and the age and sex of the child, had no bearing on the case completion rate.

As in screening completion, the type of agency the client initially patronized also seemed to have a significant effect on case completion rate. Clients requesting services at the Cuban Refugee Agency comprised 33.8% of the sample; they experienced a success rate of only 32.7%. Those clients who were referred through SES comprised 66.2% of the sample and experienced a success rate of 47.7% (see Table CM-19).

In considering Spanish type against all non-Spanish clients, there appeared to be no significant difference between Cuban-Spanish and other Spanish clients in the level of successful case completion achieved (see Table CM-20).

L. Preview of Third Year Analysis

Next year is the third and final year of the E.P.S.D.T. Demonstration Project. The final sampling will be completed, affording comprehensive data which will permit accurate conclusions. Three years of statistics will be analyzed, and

TABLE CM-18

CASE COMPLETION RATE

BY ETHNIC GROUP

ETHNIC GROUP	% TOTAL	% SUCCESS
BLACK	49.8 %	51.8 %
SPANISH	41.7 %	33.0 %
WHITE	8.5 %	37.1 %

TABLE CM-19

CASE COMPLETION RATE BY AGENCY

AGENCY	% TOTAL	% SUCCESS
CUBAN REFUGEE AGENCY	33.8 %	32.7 %
SOCIAL & ECONOMIC SERVICES	66.2 %	47.7 %

TABLE CM-20

CASE COMPLETION RATE

BY SPANISH TYPE

SPANISH TYPE	% TOTAL	% SUCCESS
CUBAN	33.8 %	32.7 %
OTHER SPANISH	8.3 %	34.8 %
NON-SPANISH	57.9 %	49.6 %

relationships that exist will be discussed. Many variables (such as age and sex of the client; sex and education level of the Health Decision-Maker, and the relationship of the Health Decision-Maker to the client; the client's ethnic group; and the agency he/she visited for aid) will be carefully evaluated for any statistical significance.

The computer reports on the first two years have undergone a number of modifications and, as a result, some analyses have presented us with missing cases. This problem is expected to be eliminated in the third year reports because of changes in the management information system that have been recommended.

The third year evaluation report will also include comparison of experimental and control conditions and a thorough review and determination of the Project's utility.

Finally, a cost analysis of the Project is expected to be completed. This analysis, along with the other available information, will be used to determine whether or not the Project was cost efficient as well as effective in terms of reaching and helping the Medicaid-eligible population.

SCHOOL INTERVENTION

I. Introduction

The School Intervention Component of the E.P.S.D.T. Demonstration Project is based on the second of the Project's major objectives -- to develop techniques of collaboration with the public school system in order to identify children with health care problems.

In this regard, the school component can be seen as a subset of case monitoring activity, in that the research objective would be to compare children receiving school intervention (in addition to case monitoring) with those children receiving case monitoring alone with the ultimate goal of improving show rates for screening and treatment. The research design calls for comparisons in the following areas:

1. Rates of shows for screening for all cases.
2. Rates of shows for the first diagnosis/treatment appointment for children who have problems identified at screening.
3. Rates of problem resolution for each problem identified at screening or during the course of treatment.
4. Rates of case completion for all cases.

The following hypotheses were formulated in the research design for this investigation:

H_0 (1): There will be no difference between the School Intervention Group and the Non-Intervention Group in the probability of children showing up for screening appointments within 60 days of the time the screening appointment is made.

H_0 (2): There will be no difference between the School Intervention Group and the Non-Intervention Group in the probability of children showing up for treatment within 60 days of screening completion.

H_0 (3): There will be nc difference between the School Intervention Group and the Non-Intervention Group in the probability of problem resolution within 120 days of screening completion.

H_0 (4): There will be no difference between the School Intervention Group and the Non-Intervention Group in the probability of case completion within 120 days of the date of screening completion.

In order to implement the study, several objectives were developed for the Schools Component:

1. To establish coordinative efforts with the school health services program to avoid duplication of services and to maximize the utilization of existing resources.
2. To develop arrangements with school personnel to remind children of health care appointments.

3. To arrange for school officials to accept medical excuses from case monitors for absence from class.

An additional component of this study was to be the identification of children with potentially handicapping conditions and the referral of such children to special education programs. And so a fourth objective was added to the program:

4. To identify handicapped children so that appropriate medical services can be offered.

Review of Fiscal Year 1976/1977

During the first fiscal year of the Project, formal agreements were executed between the Project and the Dade County School System which confirmed the Project's objectives and established a working relationship between the two agencies. Procedures for participation by the schools were established in the form of reminder letters regarding screening and treatment appointments to be conveyed to the child's parent or guardian by way of the school principals. In the area of special education, the parties established the basis for a mutual exchange of information about children with handicapping conditions, with Project staff identifying Medicaid-eligible children and obtaining parental consent prior to the identification of a handicapped child to the school. Throughout, confidentiality and the individual's right to privacy were stressed.

Toward the end of the first fiscal year, several factors were noted for future consideration which pointed to a possible effect on the conduct and outcome of the schools study. These were:

1. Screening completion rate. A high screening completion rate under basic case monitoring procedures may make it difficult to assess the effect of school intervention.
2. Process time. The health decision maker may not receive the school's reminder notice in time for it to have any effect on the keeping of an appointment.
3. Cancellations. Due to the time it takes to carry out the reminder process and the frequency of rescheduling, the health decision maker may receive a reminder about a non-existent appointment.
4. Case monitor effectiveness. Some concern was expressed about the potentially deleterious effects of the additional workload on the overall efficiency of case monitors.

II. Progress in Fiscal Year 1977/1978

A. Phase I

As noted above, the purpose of the school intervention study was to attempt to improve the appointment-keeping behavior of E.P.S.D.T. clientele by involving the public schools in the effort. For purposes of the study, intervention was defined as the joint role of the school system and Project staff in reminding parents of their child's pending screening or treatment appointment. Translated into actual performance, this meant that a notice containing details of an appointment was mailed to the child's school by the case monitor. Upon receiving the notice, the school was to pass the reminder along to the parent by means of the child. A list of public schools in the Project area was provided by the Dade County School Board (See Exhibit SI-1 for list).

Beginning in October 1977, 50 children were selected as an experimental sample from the larger pool of the case monitoring experimental group. All children completed screening and treatment by mid-March 1978. A second sample of 50 children had been selected as a control group, and were followed through screening and treatment without intervention. Both the experimental and the control group received identical treatment from their assigned case monitors, with the exception that the experimental group received, in addition, appointment reminders through their various schools. Utilizing the variables of age, ethnic group, and assigned monitor, the two groups were carefully examined to insure the absence of any systematic sampling bias.

EXHIBIT SI-1

SCHOOLS LOCATED IN E.P.S.D.T. PROJECT AREA

NAME	ADDRESS
Gladeview	6210 N.W. 27th Ave. - Miami
Poinciana Park	6745 N.W. 23rd Ave. - Miami
Liberty City	1855 N.W. 71st St. - Miami
Evans	1895 N.W. 75th St. - Miami
King	7124 N.W. 12th Ave. - Miami
Miami Northwestern Sr.	7007 N.W. 12th Ave. - Miami
Holmes	1175 N.W. 67th St. - Miami
Primary School "C"	757 N.W. 66th St. - Miami
Little River	514 N.W. 77th St. - Miami
Edison Park	500 N.W. 67th St. - Miami
Morning Side	6620 N.E. 5th Ave. - Miami
Miami Edison Middle	6100 N.W. 2nd Ave. - Miami
Miami Edison Sr.	6100 N.W. 2nd Ave. - Miami
Shadowlawn	149 N.W. 49th St. - Miami
Arcola Lake	1037 N.W. 81st St. - Miami
Drew Jr.	1801 N.W. 60th St. - Miami
Drew	1775 N.W. 60th St. - Miami
Olinda	5536 N.W. 21st Ave. - Miami
Orchard Villa	5720 N.W. 13th Ave. - Miami
C.O.P.E.	1759 N.W. 54th St. - Miami
Floral Heights	5120 N.W. 24th Ave. - Miami
Brownsville Jr.	4899 N.W. 24th Ave. - Miami
Allapattah	4700 N.W. 12th Ave. - Miami
Allapattah Jr.	1331 N.W. 46th St. - Miami
Earlington Heights	4750 N.W. 22nd Ave. - Miami
Pharr	2000 N.W. 46th St. - Miami
Miami Jackson Sr.	1751 N.W. 36th St. - Miami
Lorah Park	5160 N.W. 31st Ave. - Miami
Gladeview	6210 N.W. 27th Ave. - Miami
West Little River	2450 N.W. 84th St. - Miami
Bethune	2900 N.W. 43rd Terr. - Miami
Melrose	3050 N.W. 35th St. - Miami
Kensington Park	711 N.W. 30th Ave. - Miami
Comestock	2420 N.W. 18th Ave. - Miami
Santa Clara	1051 N.W. 29th Terr. - Miami
West Dunbar	750 N.W.20th St. - Miami
Washington Jr.	1200 N.W. 6th Ave. - Miami
Citrus Grove Jr.	2154 N.W. 5th St. - Miami
Citrus Grove	2121 N.W. 5th St. - Miami
Douglas	314 N.W. 12th St. - Miami
Wheatley	1801 N.W. 1st Place - Miami
Miramar	109 N.E. 19th St. - Miami
Dunbar	505 N.W. 20th St. - Miami
Lee Jr.	3100 N.W. 5th Ave. - Miami
Buena Vista	3001 N.W. 2nd Ave. - Miami
Miami Senior	2450 S.W. 1st St. - Miami
Riverside	221 S.W. 12th Ave. - Miami
Merritt Jr.	660 S.W. 3rd St. - Miami
South Side	45 S.W. 13th St. - Miami

See Tables SI-1 and SI-2 for assignment of clients of experimental and control groups by case monitor and by ethnic group.

TABLE SI-1

NUMBER OF CLIENTS BY GROUP AND CASE MONITOR

Case Monitor	School Intervention Group		Total Number
	Experimental	Control	
1	7	12	19
2	15	10	25
3	10	10	20
4	18	18	36
TOTAL	50	50	100

TABLE SI-2

NUMBER OF CLIENTS BY GROUP AND ETHNICITY

Ethnic Group	School Intervention Group		Total Number
	Experimental	Control	
Black	15	16	31
White	28	30	58
Spanish	7	4	11
TOTAL	50	50	100

After all screening and treatment appointments for both the experimental and the control group were completed, the data was categorized in several areas of comparison:

1. Status of first screening appointment
2. Status of all screening appointments
3. Status of all treatment appointments
4. Status of all screening and treatment appointments combined
5. Mean number of days from referral to screening completion ("referral" being the point at which the case was officially logged in by the Project).

Appointments were categorized by possible outcome: kept, and not kept. The mean number of days from referral to screening completion was calculated for the groupings of clients -- those who kept the first screening appointment; and those who completed screening, regardless of the number of appointments.

Tables SI-3, SI-4 and SI-5 present, respectively, the statistical data for first kept screening appointment, for all treatment appointments, and for all screening and treatment appointments combined. It can readily be seen that the greatest difference in screening outcome (kept versus not kept) occurred for the first screening appointment. Ninety percent of the experimental group kept their first scheduled appointment, as compared to only 59% of the control group, a difference of thirty-one percentage points. However, in

TABLE SI-3: NUMBER AND PERCENT OF SUBJECTS BY STATUS OF FIRST SCREENING APPOINTMENT

STATUS OF FIRST SCREENING APPOINTMENT	SCHOOL INTERVENTION GROUP				TOTAL	
	EXPERIMENTAL		CONTROL			
	N	%	N	%	N	%
KEPT	43	90%	23	59%	66	76%
NOT KEPT	5	10%	16	41%	21	24%
TOTAL	48	100%	39	100%	87	100%

TABLE SI-4: NUMBER AND PERCENT OF ALL TREATMENT APPOINTMENTS BY APPOINTMENT STATUS

STATUS OF ALL TREATMENT APPOINTMENTS	SCHOOL INTERVENTION GROUP				TOTAL	
	EXPERIMENTAL		CONTROL			
	N	%	N	%	N	%
KEPT	73	66%	87	71%	160	68%
NOT KEPT	38	34%	36	29%	74	32%
TOTAL	111	100%	123	100%	234	200%

TABLE SI-5: NUMBER AND PERCENT OF ALL SCREENING AND TREATMENT APPOINTMENTS APPOINTMENT STATUS

STATUS OF ALL SCREENING AND TREATMENT APPOINTMENTS	SCHOOL INTERVENTION GROUP				TOTAL	
	EXPERIMENTAL		CONTROL			
	N	%	N	%	N	%
KEPT	118	71%	124	67%	242	69%
NOT KEPT	49	29%	61	33%	110	31%
TOTAL	167	100%	185	100%	352	100%

considering treatment appointments, the difference was dramatically reduced. While 66% of treatment appointments were kept by the experimental group, 71% of their appointments were kept by the control group, an extremely small difference only slightly favoring the control group. This experience is also borne out in comparison of the status of all screening and treatment appointments combined: 71% of appointments were kept by the experimental group as compared to 67% by the control group, not a statistically significant difference.

On the assumption that an improved show rate would also result in a reduction in the length of time to accomplish screening completion, the mean number of days from case referral to screening completion was also examined. For clients who kept their first screening appointment, the experimental group registered a mean of 32 days as compared to 42 days for the control group. Furthermore, a study of the mean number of days from referral to screening completion for all clients who completed screening indicated a difference of 20 days - 34 days for the experimental group and 54 days for the control group.

The experimental and control groups were also examined by age and ethnicity to determine whether or not school intervention might have had a definite effect on a particular subset of the samples. First, both groups were divided into two age groupings, six through eleven years and twelve through eighteen years, approximately corresponding to the levels of elementary school and secondary school. Next, the samples were referenced by the categories "Spanish" and "Black and White". (Blacks and Whites were combined because they were too few white subjects to comprise a statistically meaningful group.)

Table SI-6 presents the results of a comparison of the percentage of kept appointments by the above-described breakdowns. It is readily apparent that, although the experimental group performed slightly better in all categories, there was no meaningful difference at any level.

TABLE SI-6

THE SCHOOL INTERVENTION STUDY:

A COMPARISON OF THE PERCENTAGE OF KEPT APPOINTMENTS BY EXPERIMENTAL CONDITION FOR SELECTED INDEPENDENT VARIABLES

SELECTED INDEPENDENT VARIABLES	EXPERIMENTAL CONDITION	
	EXPERIMENTAL GROUP	CONTROL GROUP
Subjects Age 6-11 Years (X^2 = 0.40)	69%	64%
Subjects Age 12-18 Years (X^2 = 0.22)	73%	68%
Spanish Subjects (X^2 = 0.18)	68%	64%
Blacks and Whites (X^2 = 0.00)	71%	70%

In reviewing the results of the study, it was felt that several elements of the research design may have raised a question about the validity of the data. First, due to time limitations related to the phase of the school year in which the study was carried out, subjects were not assigned randomly to the experimental or control groups. Sampling was accomplished at two different periods of time. Second, the small size of the total sample, 100 children, may have accentuated any sampling bias that may have existed. It was therefore recommended that a second study be carried out in an attempt to determine conclusively if school intervention has a positive effect on case completion. This decision was based on three major factors: (1) The original small sample size and the sampling technique used may have created a bias; (2) the program incurred a relatively small cost for the Project; (3) initial data indicated a definitely positive impact on the first screening appointment.

B. Phase II

The second phase of the school intervention study was put into operation on March 13, 1978, and continued until the close of school in June. A total of 97 children were sampled, 44 assigned to the experimental group and 53 to control. Two major procedural modifications were instituted in response to problems perceived in the Phase I study.

First, children were sampled in one time period and were assigned randomly to the experimental or the control group. Second, school intervention, in the form of a reminder notice, was applied only for the first screening appointment. In addition, case monitors had no means of determining if the health decision maker actually received the notice. As before, both groups received identical case management services apart from the school reminder.

Given the reduced focus of the Phase II study, the only information felt to be of significance was the percentage of kept first screening appointments. Table SI-7 details the results. It can be seen that there was very little difference between the experimental and the control group, with the control group actually showing a slightly better performance record. This appeared to be a complete contradiction of the results obtained previously. As was done in Phase I, the samples were again examined by age and ethnic group to ascertain if there was any subset effect that may have been masked by the overall results. As is shown in Table SI-8, there was little if any improvement in performance when the sample is examined in this manner. While the sub-groups "Age 12-18 years" and "Spanish subjects" appeared to have a better performance record, statistical tests considering the size of the sample demonstrated that the difference between the groups were insignificant.

TABLE SI-7

NUMBER AND PERCENT OF CLIENTS BY SCHOOL INTERVENTION GROUP AND STATUS OF FIRST SCREENING APPOINTMENT - PHASE II

STATUS OF FIRST SCREENING APPT.	SCHOOL INTERVENTION GROUP				TOTAL	
	EXPERIMENTAL		CONTROL			
	N	%	N	%	N	%
KEPT	16	36%	22	42%	38	39%
MISSED	28	64%	31	58%	59	61%
TOTAL	44	100%	53	100%	97	100%

TABLE SI-8

THE SCHOOL INTERVENTION STUDY:

A COMPARISON OF THE PERCENTAGE OF KEPT APPOINTMENTS BY EXPERIMENTAL CONDITION FOR SELECTED INDEPENDENT VARIABLES

Selected Independent Variables	Experimental Condition	
	Experimental Group	Control Group
Subjects Age 6-11 Years ($X^2 = 1.81$)	22%	43%
Subjects Age 12-18 Years ($X^2 = .70$)	63%	43%
Spanish Subjects ($X^2 = .84$)	41%	22%
Black & White Subj. ($X^2 = .71$)	36%	51%

C. Overall Review of School Intervention

A review of the data from both phases of the school intervention study unfortunately does not provide any clear answer to the question of whether or not participation by the schools has a meaningful effect on appointment-keeping behavior. It is clear that no consistent positive effect was found to exist for the group as a whole or for any of the subsets that were examined. However, several observations may reasonably be made.

One potential problem that was never entirely resolved during the school intervention study was that of the size of the sample. It was noted in Phase I that the small sample size may have exaggerated or masked any sampling bias. This problem was not really dealt with in Phase II, largely due to a lack of available subjects.

Given an unchanged sample size of 100 subjects, percentage differences in achievement proved to be relatively insignificant when actual numbers were taken into account. The Project did, however, record several factors related to availability of subjects which not only affected this study but which would definitely affect the usefulness of school intervention as a case management tool. First, nearly half of all E.P.S.D.T. eligibles do not attend school, being under 5 years of age, over 18 years, or emancipated minors. Second, schools are closed for several months of the year. Both of these conditions seriously limit access to a large proportion of the Medicaid clientele and, further, create an inconsistency factor that negatively impacts on case management as a whole.

A second observation involves the effectiveness of the experimental tool - the reminder letter. It proved to be almost impossible to determine whether reminders had been received in a timely manner or if they had, in fact, been received at all by the persons for whom they were intended. In many instances, this was complicated by the cancellation and rescheduling of appointments after the reminder for the original appointment had been sent.

In summary, it would appear that school intervention made no noticeably useful contribution to case management. While it is important for the schools to be involved in conveying to children and parents the importance of health screening and treatment as a means of improving the quality of life, it seems clear that participation by the schools on the level examined by this study serves no particularly useful purpose.

III. Identification of Handicapped Children

This section of the schools component was related to the fourth of the program objectives developed for this phase of the Project: "To identify handicapped children so that appropriate medical services can be offered." The program was begun in the second quarter of the fiscal year after arrangements were made for follow-up with the Diagnostic Resource Center of the Dade County Public School System. Federal law 94-142, The Education For All Handicapped Children Act of 1975, required that schools identify all children with handicapping conditions so that supportive services could be provided and such children guaranteed access to education. The Project's involvement in this program was designed to assist the public schools in identifying eligible children through the resources at the Project's disposal.

In November 1977, two case monitors were assigned to visit clients with children who were identified during another component of the Project (see Developmental Screening) as having possible handicapping conditions. With the consent of the parents, the appropriate school officials were notified. It was left to the school to determine if special education for a particular child was indeed appropriate and if, in fact, a special program was being implemented for that child.

During the course of the study, 48 children were so identified by the Project. Of these, parental consent for referral was obtained for 41. However, upon evaluation by the Diagnostic Resource Center, only two of these children were determined (by the Center's criteria) to be candidates for special programs. The other 39 children were deemed to be responding and performing adequately in their existing situation. Two factors may be cited to account for this situation: (1) Project-sponsored testing results could only indicate a possible or potential problem; this condition might not be borne out in the actual school setting. And (2), diagnosis in a clinical setting might not correlate with actual performance level, particularly when such performance may be related to a situational norm.

One additional condition seriously affected the program's usefulness. Policy differences that exist between the Health and Welfare Departments and the Education Department with regards to classification and administration of several evaluative tests, and the acceptability of the tests themselves, effectively negated the applicability of the test results and the diagnostic work performed under the Project's supervision. It is certainly clear that these various agencies, at least, must coordinate their efforts, particularly with regard to a uniformity of definitions, policies, and standards, before such programs as these can be of any benefit to their mutual clients.

DEVELOPMENTAL SCREENING

I. Introduction

The Developmental Screening Component relates to the third of the major program goals and concerns the assessment of various techniques for developmental screening to determine their appropriateness for use in detecting developmental disabilities. The following objectives have been established:

1. To select techniques that can be used to identify and assess children with developmental problems.
2. To determine the types of problems identified by each screening technique.
3. To evaluate the validity of each technique in identifying developmental problems.
4. To determine the relative cost of each technique.

Three research objectives have also been formulated in order to determine the validity, sensitivity, and cost of each technique. These are:

1. To compare screening results with the results of diagnosis.
2. To categorize problems that are identified at screening and are confirmed by diagnosis.
3. To determine the cost per screen in terms of the rate of confirmed screens.

The following hypotheses will therefore be applied to each developmental screening technique being utilized:

$H_o(1)$: The probability of false negative screens and false positive screens will be zero.

$H_o(2)$: The probability of false negative screens and false positive screens will be zero for each category of developmental problems identified in diagnosis.

To clarify these objectives and hypotheses, and the discussion that follows, the following definitions will apply:

1. Negative screen - The absence of problems as determined by the screening technique.
2. Positive screen - The existence of problems as determined by the screening technique.
3. Confirmed screen - Problems identified at screening which are diagnosed as real problems; conversely, a negative diagnosis for a case in which no problems were identified at screening.
4. False positive screen - Problems identified at screening which are not confirmed by diagnosis.
5. False negative screen - Problems found in diagnosis which were not identified through the screening technique.
6. Sensitivity - The number of true positives identified by the screening technique, divided by the total number of diagnostic positives.
7. Specificity - The number of true negatives identified

by the screening technique, divided by the total number of diagnostic negatives.

Review of First Fiscal Year

During the first fiscal year of Project operation, two screening techniques were selected for evaluation: the Psychological Screening Inventory (PSI) and the Zero Input Tracking Analyzer/Auxiliary Distraction Task (ZITA/ADT). The PSI, a so-called "traditional" technique, is based on a psycholinguistic communications model and was developed by Dr. Ruth Pinnas and associates at the University of Miami. The test is intended to determine if and how the subject receives information from various environmental stimuli. The ZITA/ADT is an automated method developed by Norman K. Walker of Norman K. Walker Associates, Rockville, Maryland. It is used to detect and assess minimal brain dysfunction by measuring the subject's performance on a simple one-hand tracking task, performed first by itself and then in conjunction with a competing response task performed by the other hand. For a more detailed description of both techniques, their application, components, and performance scoring, see the E.P.S.D.T. Demonstration Project Evaluation Report for the First Fiscal Year.

Several areas of concern were identified during the initial phase of the program. These included a potential effect on test results caused by the subject selection and test administration methods used by individual testers; a possible violation of blind study procedures caused by the involvement of staff from the same source in both the testing and diagnostic elements of the program; deviation from established procedures in the areas of test scoring, referrals for diagnosis, and reporting of diagnostic results; expiration of subject's Medicaid eligibility prior to referral for diagnosis or treatment; and the difficulty of maintaining, correlating, and analyzing study data without some computerization of the information being compiled during the study.

II. Progress in Fiscal Year 1977/1978

A. Restructuring of Procedures

As noted above, several of the areas of concern noted in the first fiscal year had to do with procedural questions. Originally, the Project contracted with the Comprehensive Health Care Program (CHCP) of the University of Miami Department of Pediatrics to incorporate use of the PSI and the ZITA/ADT in the regular screening progress and with Dr. Fred Seligman, also of the University of Miami, to accept referrals for diagnosis. Subjects being screened were randomly assigned to ZITA/ADT or PSI, and the test results scored by Project staff. All positive screens and some negative screens were referred for diagnosis. After diagnostic results were returned to the Project, each screening device was to be evaluated as to its ability to detect children at high risk of developmental disorders.

Several major problems developed early in the implementation of these procedures. In the first place, it was difficult to get children to return for diagnosis after having been screened -- the Project experienced a less than 50% show rate for diagnostic appointments. Second, due in large part to the small number of subjects showing up for diagnosis, too few negative screens were being diagnosed to permit the calculation of variables used to evaluate the screening techniques. Thirdly, and again a function of the small number of subjects, so many different diagnoses were reported with so few in each category that the usefulness of this material for analytical purposes were extremely limited. In light of these problems, and in consideration of concerns raised in the first fiscal year regarding tester effect, blind study violations, and procedural deviations, it was decided that several major procedural changes be effected.

During the third quarter of the fiscal year, an agreement was reached with the Greater Miami Epilepsy Foundation to provide an alternative diagnostic source to the University of Miami Department of Psychiatry. Originally, children to be diagnosed by Epilepsy Foundation personnel were to be selected from the group of E.P.S.D.T. eligible clients in the Project's service area and offered the opportunity for free developmental diagnosis and follow-up treatment, if needed. However, as too few clients were willing to participate, the focus was changed to a local public elementary school where the Epilepsy Foundation was already providing services. A sufficient number responded positively to this approach to provide adequate resources.

Under the revised procedures, the various types of diagnosed abnormalities are being classified as intellectual dysfunctions, emotional problems, and learning disabilities (neuro-behavioral dysfunction). The quantitative results of a WISC-R intelligence test are also included in the diagnostic evaluation. Children being diagnosed by the University of Miami staff are selected from among E.P.S.D.T. clients at the Comprehensive Health Care Program; intelligence test administration, diagnostic evaluation, and screening on both ZITA and PSI all take place on the same day. Children selected for the Epilepsy Foundation program are screened on ZITA and PSI at their school by Project staff; administration of intelligence test and the diagnostic evaluation by an Epilepsy Foundation psychologist are then scheduled for a later date.

The several problems encountered in the initial stages of the program have therefore been alleviated as follows:

1. Emphasis has been placed on eliminating special trips for screening and for diagnosis. At CHCP, screening and diagnostic evaluation take place on the same day;

for the Epilepsy Foundation program, children are screened and diagnosed at school, thus eliminating the need for absences or transportation.

2. All children in the program are diagnosed, regardless of screening outcome, thus eliminating the scarcity of diagnoses for negatively-screened subjects.
3. All children are screened on both ZITA/ADT and PSI, providing twice as much analytical data and permitting additional comparison between the two screening techniques.

The revised procedures were put into operation at the University of Miami on March 31, 1978, and at the Epilepsy Foundation on March 20, 1978. Actual screening and diagnosis by the University began on May 5, 1978; thirty-four children completed all phases by the end of June. The Epilepsy Foundation began its program in mid-June. Thirty-seven children had completed PSI screening by the end of the month and, of these, twenty had also completed ZITA/ADT screening and nine had been diagnosed.

B. Categorization of Diagnoses

In addition to the grouping of diagnoses into three general categories -- intellectual dysfunctions, emotional problems, and learning disabilities -- five categories of diagnostic recommendations are presented for confirmed positives. These are:

1. No further treatment needed.
2. Limited counseling recommended. (In some cases, this can be accomplished by the examiner in one or two sessions).
3. Intermediate counseling recommended (several sessions required).
4. Long-term therapy recommended (provided by resources within the program or by referral to external resources, depending on the nature of the problem).
5. No referral recommended because of poor prognosis. (This may be due to such factors as limited resources, family limitations, cultural settling, family resistance, etc. Recommendations for treatment are made).

C. Data Report

Since the Developmental Screening component became operational in May of 1977, a total of 482 children had been screened by the end of the second fiscal year. Of these, 109 children had also received diagnostic evaluation. The preliminary screening outcome data (see Table DS-1) indicates a higher rate of positive screens for ZITA than for the PSI. However, a look at diagnostic results shows a much higher rate of screening confirmations for PSI (see Table DS-2), which would certainly cast some doubt on the validity of the ZITA screening reports.

TABLE DS-1

ZITA AND PSI SCREENING OUTCOME

JULY 1, 1977 - SEPTEMBER 30, 1977

SCREENING TEST	OUTCOME					
	POSITIVE		NEGATIVE		TOTAL	
	N	%	N	%	N	%
ZITA	59	64	33	36	92	100
PSI	42	43	56	57	98	100
TOTAL	101	53	89	47	190	100

TABLE DS-2

DIAGNOSTIC OUTCOMES FOR 99 CHILDREN WITH POSITIVE SCREENING RESULTS ON THE ZITA OR PSI TEST

(JULY 1 THROUGH NOVEMBER 30, 1977)

DIAGNOSTIC OUTCOME	SCREENING TECHNIQUE					
	ZITA		PSI		TOTAL	
	NUMBER	PERCENT	NUMBER	PERCENT	NUMBER	PERCENT
Screening Results Confirmed by Diagnosis	26	59%	41	75%	67	68%
Screening Results Not Confirmed By Diagnosis	18	41%	14	25%	32	32%
TOTAL	44	100%	55	100%	99	100%

It must be remembered that the data reported to date relates almost entirely to the procedures that were in effect for the first half of the fiscal year. The revised procedures described above -- with screening and diagnosis being undertaken by two separate resources, with all participating children being screened on both devises, and with the emphasis placed on screening and diagnosis being accomplished in a more convenient and advantageous setting and time frame -- did not become operational until the last two months of the fiscal year. Data to support any firm conclusions about the accuracy and expediency of the screening methodologies being tested will not, therefore, be available until the third year of the Project.

The same holds true for the pattern of diagnoses that have been reported to the Project. Upwards of twenty different diagnoses have been noted. This fact, combined with the relatively small number of children who have completed diagnosis, gives rise to an inflated percentage in all diagnostic categories. The reported diagnoses range from hearing loss and impaired vision, through various levels of mental retardation, to depressions and borderline psychosis. The most frequently diagnosed condition is that of mental retardation followed closely by adjustment reaction (see Exhibit DS-1).

EXHIBIT DS-1

FREQUENCY ANALYSIS FOR DEVELOPMENTAL SCREENING DIAGNOSES

THROUGH OCTOBER 26, 1977

DIAGNOSIS	SCREENING TEST			
	ZITA		PSI	
	N	%	N	%
Minimal Brain Dysfunction	2	06	2	07
Borderline Mental Retardation	4	11	6	21
Borderline Mental Retardation - Trauma or Physical Agent	1	03	-	-
Borderline Mental Retardation - Disorders of Metabolism, Growth or Nutrition	1	03	-	-
Mild Mental Retardation	-	-	2	07
Mild Mental Retardation - Psycho-social (environmental) depravation	1	03	-	-
Hyperkinetic reaction	-	-	1	04
Overanxious reaction	1	03	3	11
Unsocialized aggressive reaction	1	03	-	-
Adjustment reaction of childhood	4	11	5	17
Adjustment reaction of adolescence	-	-	2	07
Disorders of Sleep	3	09	3	11
Neurosis-Depressive	2	06	-	-
Hearing Loss	2	06	-	-
Borderline Psychosis	1	03	3	11
Visual Impairment	1	03	-	-

(continues...)

FREQUENCY ANALYSIS FOR DEVELOPMENTAL SCREENING DIAGNOSES

THROUGH OCTOBER 26, 1977

PAGE 2

DIAGNOSIS	SCREENING TEST			
	ZITA		PSI	
	N	%	N	%
Reaction Depression	2	06	-	-
Environmental Depravation	2	06	-	-
Psychopathology	1	06	-	-
Neurological Immaturity	1	03	-	-
Affective Disorder-Depression	1	03	-	-
Possible Thought Disorder	1	03	-	-
	33	100	28	100

III. Preview of Evaluation Areas for Fiscal Year 1978/1979

Under the revised operating procedures put into effect toward the end of the second fiscal year, it is anticipated that 100 children will be screened and diagnosed by each contracting agency by the end of December 1978.

In the diagnostic evaluations, children will be considered for intellectual deviations from the norm, for learning disabilities, and for emotional problems. Diagnostic reports will be based on the results of a standardized test (such as the WISC-R or the ITPA) and a personal evaluation by a psychologist or psychiatrist, and will include note of the presence or absence of defects in each of the three areas noted above.

Screening results for both ZITA/ADT and PSI will be classified as either "positive" (indicating the presence of developmental disability) or "negative" (the absence of any such indication). Classification will be based on test data supplied by the developers of each procedure, and will be age-adjusted.

Given the results of screening and diagnostic evaluation, each subject will be classified as "developmentally disabled" or "not developmentally disabled", the former being defined as one who has been positively rated in one or more of the three diagnostic areas, and the latter as one who received no positive rating in any area. To compare screening outcome with diagnostic evaluation, a four-fold classification table will be used for each of the three diagnostic areas by screening procedure, and for the overall designations of "developmentally disabled" and "not developmentally disabled" (See Figure 1).

FIGURE 1

CALCULATING AN EVALUATIVE PROFILE OF A SCREENING TEST

Test Result	Positive	Reference Test Negative	Total
Positive	a	b	a + b
Negative	c	d	c + d
Total	a + c	b + d	a + b + c + d

Five areas of calculation will measure the validity of each screening test: sensitivity, specificity, underreferral, overreferral, and phi. Sensitivity is the ability of the screening test to identify correctly all of the confirmed positive children. Specificity relates to the test's ability to detect all of the confirmed negative children. Underreferral is the ratio of children missed to the total number screened. Overreferral is the ratio of children referred to the total number screened. Phi is a correlation of the other four factors which expresses the results on a scale ranging from +1.0 (perfect positive correlation) to -1.0 (perfect negative correlation). The individual formulas, in reference to Figure 1, are as follows:

Sensitivity = $\frac{a}{a + c}$

Specificity = $\frac{d}{b + d}$

Underreferral = $\frac{a}{a+b+c+d}$

Overreferral $\frac{b}{a+b+c+d}$

Phi = $\frac{(ad - bc)}{\sqrt{(a+b)(c+d)(a+c)(b+d)}}$

The use of two separate sources for screening and diagnosis will not only increase the ultimate size of the sample, but will also permit the comparison of two different perspectives in the consideration of developmental disabilities. Furthermore, the testing of the same group of children on two different screening devices will give a much better indication of the validity of screening results.

THE OLDER CHILD

I. Introduction and Review of Fiscal Year 1976/1977

The fourth of the project's program goals is the development of innovative approaches for making Medicaid sevices more appropriate and relevant to the Older Child, nine through twenty years of age. The Project has determined to meet this objective through the creation of a multi-media information package for providers of health services. This will include:

1. Diagnostic guidelines for physicians regarding problems commonly found in older children.
2. Guidelines for the identification of high-risk children.
3. Material aimed at developing clinical expertise in physicians who are treating older children.
4. Culturally appropriate and problem-referral resources.

The research design for testing this package has been divided into two areas:

1. The comparison of Medicaid providers who receive the information package (Experimental Condition) with a control group of providers who do not, in terms of:
    a. Types of problems these providers identify in their older child patient population;
    b. Frequency and types of referrals they make for these problems.

2. Obtaining descriptive data from the experimental group of providers regarding the usefulness of the information package in identifying problems experienced by their older child patients, and in making referrals for these problems.

During the first fiscal year, arrangements were concluded with the primary consultants at the Grant Center Hospital and Treatment Center for the collaborative development of the information package, and contact was established with other programs around the county which are presently dealing with the problems of the Older Child.

II. Progress in Fiscal Year 1977/1978

Throughout the second fiscal year meetings were held with the Grant Center contractors regarding development of the resource work to be entitled, The Handbook of Special Problems in Teenagers. A consultation staff of professional experts, including physicians, psychologists, and other people involved in providing health care services to adolescents, was organized. It was determined that the final information package will include a bibliography, a diagnostic criteria section, a glossary of terms, and a cross-referencing of content information.

A working draft of the Handbook was completed toward the end of the fiscal year. It has been circulated to a few knowledgeable professionals for their opinion and comments prior to formal distribution for testing.

III. Preview of Evaluation Activities for Fiscal Year 1978/1979

It is anticipated that the final draft of the *Handbook*, as well as companion materials in the form of posters, graphics, and desk reference, will be ready for distribution by the the middle of the third fiscal year. Approximately 150 to 200 Medicaid providers will be selected to receive the package from among a larger group of providers who will be asked to indicate their interest in participating in the program.

After all materials have been distributed and the providers have been allowed sufficient time to review the package, the experimental group will be surveyed by written questionnaire to determine their reactions. Questions will focus on the presentability of the package, the validity of the contents, and the useability of the format. General information about their types of practice, and frequency of referrals and contacts with social agencies, will also be solicited. The results of this survey will be reviewed in the evaluation report for the third fiscal year.

INTERAGENCY COLLABORATION

I. Introduction

The fifth goal of the Demonstration Project calls for the development of resources and support for the Project's objectives among community agencies, health care providers, and social service leadership. Several specific component objectives have been established to serve this goal. They are:

1. To identify community agencies which provide health care services to Medicaid-eligible children.
2. To establish an Advisory Council which will:
   a. Identify problems in delivering health care services to Medicaid-eligible children and recommend solutions to these problems to improve methods for delivery of health care services.
   b. Facilitate the development of referral relationships among agencies which provide E.P.S.D.T. services.
   c. Describe health care services offered by member agencies.
   d. Provide input for the future direction of the Project.

A. Review of Fiscal Year 1976/1977

During the first fiscal year, both of the major program objectives were addressed. Project staff identified community resources to assist in the provision of health care to Medicaid-eligible children, and an Advisory Council of twenty-three members was organized. The two meetings of the Advisory Council that were held during the first year were largely concerned with orientation to the Project, its goals and objectives, its component activities, and its staff.

II. Progress in Fiscal Year 1977/1978

The Advisory Council members formally met on five occasions in the second fiscal year, continuing their orientation to Project activities and becoming involved with the interrelationship of their respective agencies as they impacted on Project clientele.

Through these discussions, the Council identified and recommended action on a number of issues affecting the conduct of the Project.

1. Authorization for medical services by someone other than parent of legal guardian. It was determined that ten to twelve percent of E.P.S.D.T. eligible children in Dade County resided with a relative who was neither their parent nor their legal guardian. Such a person was therefore not legally empowered to obtain other than emergency health care services for the children in their charge. Council members and staff worked with SES and with Legal Services to obtain a court order allowing non-parent relatives to authorize medical care (see Exhibits IC-1 and IC-2, "Affidavit of Insolvency"

and "Petition for Authorization to Consent to Screening and Necessary Medical Treatment").

2. Availability of Medicaid services to institutionalized Children. It was discovered that there existed no procedure for making Medicaid services available to children who reside in public and private institutions in custody of the Department of Health and Rehabilitative Services. Council members determined that the Florida State Health Care Plan would have to be modified in order to secure Medicaid eligibility for such children. Meetings have been scheduled with various appropriate State personnel to explore alternatives in this regard.

3. Public education regarding E.P.S.D.T. eligibility. Project staff discovered that potential clients for E.P.S.D.T. services were not being adequately informed as to eligibility criteria and available resources. With the assistance of Council members, orientation programs for SES workers were organized through the HRS General Services Supervisor and the Training Program Coordinator for Staff Development.

4. Delays in provider reimbursement. One factor that can be considered largely responsible for the increasing reluctance of health care providers to participate in Medicaid-related programs is that of delayed reimbursement. Due to requirements for verification of screening results prior to treatment for certain dental, visual,

Exhibit IC-1

AFFIDAVIT

STATE OF FLORIDA)
) SS.
COUNTY OF DADE)

Before me, the undersigned authority, personally appeared, ________________, who after being duly cautioned and sworn under oath, deposes and says:

1. That s/he is the social worker for the Petitioner and the minor(s).

2. That the Petitioner does, in fact, receive an AFDC grant from the State of Florida for the care of the minor(s).

________________________, Social Worker

Sworn to and subscribed
before me this day
of , 19 .

____
NOTARY PUBLIC STATE OF FLORIDA

ORDER

IT IS HEREBY ORDERED and ADJUDGED that this Petition is granted, and Petitioner is given authorization to consent to the screening and medical treatment of the above named minor(s).

So ORDERED, this day of , 19 .

____

CIRCUIT COURT JUDGE

Exhibit IC-2

IN THE CIRCUIT COURT OF THE 11TH
JUDICIAL CIRCUIT IN AND FOR DADE
COUNTY, FLORIDA.

JUVENILE - FAMILY DIVISION
CASE NO.

IN RE: :

:

Minor(s) :

by ;

Petitioner. :

PETITION FOR AUTHORIZATION TO CONSENT TO SCREENING AND NECESSARY MEDICAL TREATMENT OF MINOR(S)

Petitioner asks this court for authorization to consent to the screening and necessary medical treatment of the above named minor(s), and as grounds therefore states as follows:

1. Petitioner is the __________of the minor(s), who presently reside(s) with Petitioner at____________________, Florida.

2. Petitioner has assumed responsibility for the care and support of the minor(s), and receives an Aid for Families with Dependent Children grant (A.F.D.C.) from the State of Florida for the care of the minor(s).

3. All A.F.D.C. recipients are eligible for Medicaid benefits, including periodic screening, diagnosis, and treatment for medical problems through the EPSDT program, pursuant to 45 C.F.R. §249.10(a) (3), Florida Statutes §409.266 and Rule 10C-7.16, Rules of the Department of Health and Rehabilitative Services.

4. Participation in the EPSDT program is necessary for the welfare of the minor(s).

5. The minor(s) cannot participate in the EPSDT program without the consent of a parent, guardian, or otherwise authorized individual.

6. The mother of the minor(s)________________and the father of the minor(s)_______________________.

7. Petitioner is an appropriate person to give such consent, and further it is in the best interest of the minor(s) to authorize Petitioner to give such consent.

8. The relief sought by Petitioner is authorized pursuant to this Court's "broad discretion in making orders protecting (infants') welfare." Brown v. Ripley, 119 So.2d 712, 717 (1st DCA 1960).

WHEREFORE, Petitioner requests this Court to authorize Petitioner to consent to the screening and medical treatment of the above named minor(s).

____

, Petitioner

and hearing problems, reimbursement to providers was frequently delayed, leading to provider frustrations with the program. The Medicaid Services Department of HRS in Dade County reported approximately 80 to 100 telephone calls per week on this subject alone. Council members and staff met with a variety of parties concerned with screening and reimbursement. As a result, new reporting procedures were recommended and adopted, reducing processing time and expediting payment. Project staff also supplied support to the providers by making periodic visits to their offices and by serving as liaison, when necessary, between the provider and the Medicaid program in dealing with any problems involving costs and reimbursement.

Two other issues were identified by the Council and earmarked for future attention. The first was the securing of reimbursement for problems not traditionally covered by Medicaid (such as orthodontia) and for newly developed treatment and screening procedures. The second was the development of procedures for special screening of residents of institutions for retarded children so that they, too, might receive treatment for non-emergency health problems under Medicaid authorizations.

In addition to individual involvement in problem-solving, the Council as a whole was involved in several collateral Project activities.

1. Public education. Project staff felt that potential clients for E.P.S.D.T. services were not being adequately informed by SES workers as to eligibility requirements and availability of services; for example: case monitors reported instances of clients being informed that children under one year of age or married women under age 21 were not eligible for free medical and dental care. In many cases, clients were signing a form requesting E.P.S.D.T. services without having any understanding of what those services actually were. An ad hoc committee of the Council was formed to concern itself with public education regarding E.P.S.D.T. services. Conferences were held between Council members and the HRS General Services Supervisor for the Project area at which alternative solutions were discussed and recommended, and made. The findings of this group were distributed to all SES supervisors, and led to revisions in pre-employment training and orientation. This committee of the Council was also charged with the development of health education skills for case monitors, to improve the ability to market E.P.S.D.T. programs and to deal with clients who were doubtful of accepting Project services.
2. Child Abuse. Following the discovery of several suspected cases of child abuse among its clientele, the Project

was asked by HRS to become involved in coordinating and obtaining medical services for such children and their families. Several meetings were held with HRs personnel, with police, and with related health agencies and organizations such as the Dade County Mental Health Association, the HRS Youth Services Program office, and area attorneys. Preliminary efforts were directed towards understanding existing laws regarding battered children and to determining the resources available in the community. The possiblity of organizing educational and training programs for persons dealing directly with child abuse victims is also being considered.

III. Preview of Evaluation Activities in Fiscal Year 1978/1979

Following initial orientation to Project programs and objectives, the Council has spent its second year identifying issues which have affected Project operations and participating in the development of solutions for identified problems. During the latter part of the third year, Council members will be asked to assess their role in the E.P.S.D.T. program and to evaluate their effectiveness as a coordinating influence on agencies and providers serving Medicaid-eligible children. It is presently anticipated that this will be accomplished through written questionnaires, group meetings, and personal interviews to ascertain the perceptions of individual Council members and to assess the group's perceived role in the Project itself.

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